Developing Primary Health Care Delivery in Lower and Middle Income Countries: Challenges Faced and Lessons Learned

Boston, MA
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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AEFI</td>
<td>Adverse Events Following Immunization</td>
</tr>
<tr>
<td>AMQ</td>
<td>Quality Improvement Tool (English translation of Portuguese acronym)</td>
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<tr>
<td>BMGF</td>
<td>Bill &amp; Melinda Gates Foundation</td>
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<tr>
<td>CCT</td>
<td>Conditional Cash Transfer</td>
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<td>CHA</td>
<td>Community Health Agents</td>
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<td>CEmOC</td>
<td>Comprehensive Emergency Obstetric Care</td>
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<td>DPT</td>
<td>Refers to a class of combination vaccines against three infectious diseases in humans: diphtheria, pertussis (whooping cough) and tetanus</td>
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<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GoSL</td>
<td>Government of Sri Lanka</td>
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<td>FHP</td>
<td>Family Health Program</td>
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<td>FHT</td>
<td>Family Health Team</td>
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<td>GHLI</td>
<td>Global Health Leadership Institute</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<td>HEP</td>
<td>Health Extension Program/Platform</td>
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<td>HEW</td>
<td>Health Extension Worker</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HP</td>
<td>Health Post</td>
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<td>HSDP</td>
<td>Health Sector Development Program</td>
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<td>HSPH</td>
<td>Harvard School of Public Health</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<td>MOH</td>
<td>Medical Officer of Health</td>
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<td>NACCD</td>
<td>National Advisory Committee on Communicable Diseases</td>
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<td>OECD</td>
<td>Organization for Economic Co-operation and Development</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PROESF</td>
<td>Family Health Strategy Expansion Project</td>
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<td>PROGRAB</td>
<td>Performance Management Tool for Teams</td>
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<tr>
<td>PHM</td>
<td>Public Health Midwife</td>
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<tr>
<td>RHB</td>
<td>Regional Health Bureau</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TTBA</td>
<td>Trained Traditional Birth Attendants</td>
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<tr>
<td>USD</td>
<td>United States Dollar</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WONCA</td>
<td>World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians</td>
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Overview and Objectives

Harvard School of Public Health (HSPH) and Yale Global Health Leadership Institute (GHLI) are collaborating with Ethiopia’s Federal Ministry of Health (FMOH) on a project to assist with visioning the medium to long term development of Ethiopia’s Health Extension Program (HEP) – the FMOH’s strategy for primary health care development. Funding for this project comes from the Bill & Melinda Gates Foundation (BMGF).

In order to assist the FMOH in generating strategies to further develop the HEP into an effective and sustainable primary health care delivery system, a two-day convening was held in Boston from July 30-31, 2012 to share the experiences from other countries in developing primary health care delivery.

Faculty and practitioners from the World Health Organization (WHO), Harvard University, and Yale University provided an introduction to the convening, including a conceptual framework for understanding primary care; an overview of primary care in the context of national development and health systems development; and key domains for capacity development and sustainability of primary health delivery.

In addition to Ethiopia, three countries (Brazil, Estonia, and Sri Lanka) presented the key innovations and timelines for development of their primary care systems. To conclude the convening, panelists from South Africa, Thailand and the Organization for Economic Co-operation and Development (OECD) shared reflections from the case studies and lessons learned globally in developing primary care delivery systems.

This report presents a summary of each session, focusing on the unique characteristics of primary care delivery systems in four countries (Brazil, Estonia, Sri Lanka and Ethiopia). While speakers were diverse in their approaches to describing their systems, we have tried to capture key points and general timelines. The sections on each country’s presentation reflect what was presented during this convening, and is not intended to be a comprehensive, academic review of their health systems. All statistics are from the presenter’s slides, and are thus not referenced otherwise. Presentations are available upon request.
Session One: Primary Health Care Delivery and Health Systems Development

Dr. Wim van Lerberghe, Director of Health Governance and Work Force, WHO

Dr. Wim van Lerberghe, Director of Health Governance and Work Force at the WHO in Geneva presented on the general characteristics of primary care. Dr. van Lerberghe noted several characteristics that are key to good care; namely, a professional workforce and services that are safe, comprehensive, integrated, continuous, and respectful of the user. In expanding on the need for professionals in the workforce, he commented that if a health system starts with a voluntary or non-professional workforce, such as the barefoot health care workers in China, at some point the system will have to be upgraded through a process of professionalization. Volunteers or unskilled workers will not meet the needs of an expanding and complex health system.

When speaking of the need for safety, he explained that ensuring safety includes matching the appropriate level of technological intervention to a health systems’ level of development and capacity to integrate technology. He articulated that care that is comprehensive and integrated deals with the whole patient, as well as integrating the provision of various services. With regards to continuity, he stated that good care requires continuity both throughout the lifecycle, as well as between types of care providers. Finally, he explored how services that are respectful of the user treat people within the context of their community. While this is, as Dr. van Lerberghe put it, a “fluffy” characteristic, key-informant interviews in several countries have shown that people-centered care is incredibly important to patients, and ultimately makes care more effective.

Dr. van Lerberghe explained how providing care with these characteristics has organizational consequences. Conventionally, in typical post-colonial countries, health care is organized with a hospital and antenna dispensaries that provide medical care to populations where the distance is too great to reach a hospital. This continues to be the structure of the public sector in low and middle-income countries. In reality, however, most systems are very pluralistic, with a multitude of other kinds of providers, which are often not organized in a way that delivers good care. The systems are very hospital-centered, and are responsible only for the patients that walk in to the hospitals, rather than for the communities that they are a part of. Additionally, he pointed out that care is most often not coordinated to have personal relationships between providers and the people they serve, and care is treated as a financial transaction for a purchase of a service.

Dr. van Lerberghe suggests that rather than having hospitals at the center of the organizational structure, the community should be at the center with a team of primary care providers to support them. The team should have responsibility for the health of the entire community – both those that use the services and those that do not. There must also be networks that allow
for the development of personal relationships. The primary care provider should be the gatekeeper and point of access to care, with back up of hospital and preventive care services.

Dr. van Lerberghe highlighted that the development of a primary care system is not just a matter of reorganizing care. Rather than starting with an administrative hierarchy and trying to organize care from there, he believes you should start with focusing on the outcomes you would like to achieve, and organize care based on these outcomes. He stated that you should not reorganize your care without also making an effort to have universal coverage, which provides social protection. Service delivery and social protection should go hand in hand, and should be integrated into public health and public policy.

In conclusion, Dr. van Lerberghe highlighted that if a health system is allowed to evolve on its own, it will stray from the goals of equity, universal access, and healthy communities. The system will start focusing on hospitals, and will commercialize and fragment. Thus, changes must be actively directed with regard to the composition of providers, payment systems, and the involvement of the community. For a health system to be reoriented towards primary care, he stated, a country must often overcome a lot of resistance and get political support for this transition. Generating political will to develop a primary care-focused system is feasible, and several countries that attended the convening are excellent examples of how rapidly this change can be implemented.

Session 2: Development of Primary Care Systems in the Context of Overall National Development and Health Systems Development

Peter Berman, Professor of the Practice of Global Health Systems and Economics, Harvard School of Public Health

Peter Berman, Professor of the Practice of Global Health Systems and Economics in the Harvard School of Public Health, presented on the development of primary care systems in the context of overall development and health systems development. Prof. Berman’s presentation aimed to move the conversation from some of the conceptual aspects of the development of primary care, to some more concrete elements. He also wanted to raise difficult questions related to the innate discrepancies between the type of primary care systems countries want to develop, and what is feasible, given various constraints. Acknowledging the reality that countries are at different levels of economic development, Prof. Berman hoped to explore what can be achieved at various levels of development, and some of the important decisions that need to be made along the way.

Prof. Berman presented a list of constraints that all countries face to some degree, which low and middle-income countries face to a greater degree. These include:

Politics
Things like the political power of the elite and urban populations, and the demand they place on the state for subsidized secondary and tertiary services can be an important constraint on state action. The experience that leaders have in developing health care systems can either constrain or contribute to progress. Political movements that focus on equity and reducing disparities and government commitment to producing results are factors that can accelerate progress towards achieving health care goals.

**Finances**
The capacity of government to raise money is critical if health services are to be controlled and financed as a public service. There are however, large differences in health outcomes across the spectrum of health expenditure as a percent of Gross Domestic Product (GDP).

**Human Resources**
The international community has decided that there is a certain minimum level of human resources necessary for a well-functioning health system. Prof. Berman however believes that one specific norm may not be that useful- again, there is great variability in outcomes at different levels of human resources. While human resources are a constraint, they may not be an absolute constraint simply in terms of numbers of health personnel.

**Organization and management**
Health information systems (HIS) will develop dramatically in complexity and usefulness as countries grow.

**Physical environment**
A country such as Ethiopia is going to face certain challenges in delivering care due to its large size, extensive rural population, and mountainous terrain, which makes developing a supply chain and referral system difficult.

**Social and cultural issues**
Cultural practices can impede progress towards achieving public health and primary care goals, particularly those that require individual change (rather than change in a system or environment) to achieve the desired outcome.

A common theme of Prof. Berman’s presentation was the observation that while these constraints can hinder a country’s ability to achieve their health objectives, there is great variability in how these factors actually constrain health system performance. There are countries that perform better and countries that perform worse at every level of development. He sees this as being good news, as this indicates that even low resource countries, such as Ethiopia, can perform quite well, even when these constraints are somewhat binding. Rather than focusing on the averages, it is valuable to look at the variability in performance.

Prof. Berman asked the question: “To what extent do lower resources and low capacity affect the scope of services available at a primary health center?” He noted that this tends to be a controversial issue, as some view primary care as something that should be comprehensive and integrated, and there is a tendency to narrow the scope of services when resources are constrained. Others see this is a natural function of capacity in the system, and as something to
be considered and managed as a country develops. Using lower cost technologies is one way to buffer this problem.

Prof. Berman discussed quality of care, saying that technical quality should be adequate, whatever the scope of services provided. Focus on rapidly expanding the scope of services can result in providing services of low technical quality. Perceived quality is also important, which is a struggle for countries where a competing private sector is present. The private sector can undermine the perceived quality of public services, both in terms of offering competitive packages, as well as providing better prescription drugs, medical equipment, and more flexible hours, which appeal to consumers. The private sector can thus undermine the perceived quality of the public sector.

Prof. Berman moved on to talk about pathways of development of health systems, noting that there is not much in the published literature looking at how countries move from a low resource, low access and low quality health care environment to a higher resource, higher access and higher quality health care environment. Available literature is overly simplistic, breaks down development into just a few stages, and uses simplistic indicators as proxies for access and coverage of services. Other literature does show that better outcomes are achievable even at low cost, but lacks a very detailed analysis of what factors were present in these cases. An example is Niger, where good outcomes were achieved and documented, but there is little detail about what was happening on the ground that facilitated these achievements.

Prof. Berman highlighted that in approaching the transition from poor to improved provision of services, there should be some kind of growth path, where there is a positive relationship between investments and outcome. He acknowledged that key decisions must be made by countries to determine how they move down this pathway, such as deciding whether to expand primary care, rapidly increasing access but limiting scope of services, or to build up a comprehensive package of services first and then expand services. Governments need to decide their approach, and the pathway that results will vary widely.

The big question remains, how can a country plan for their growth path? Financing strategies, organizational design, mechanisms for governance, accountability and management, interface with local communities, and the interactions across government departments and programs will all be very important. Looking into each of these areas will help us understand how countries have navigated these choices, and how their choices affected their growth path. Prof. Berman listed many important questions that a country must ask itself with regard to financing, governance and the role of the community that are integral in deciding which pathway a country will pursue, and what the performance and outcome implications will be.

He concluded by highlighting that investigating the experience of other countries is a very good way to understand how a country can move along a pathway to improving its primary care system, and understand how to overcome the constraints faced along the way.
Session 3: Key Domains of Primary Health Care Delivery Capacity Development and Sustainability

Elizabeth Bradley, Professor of Public Health Policy and Director of the Global Health Leadership Institute, Yale School of Public Health

Elizabeth Bradley, Director of the Global Health Leadership Institute at the Yale School of Public Health gave a presentation titled “Primary Care in Low- and Middle-Income Countries: A Framework for Capacity Development and Sustainability”. Prof. Bradley’s presentation focused on finding a common set of elements necessary for the development of all primary health care systems. She acknowledged that there are two basic approaches to designing a primary health care system – a selective approach and a comprehensive approach. An example of a selective approach would be where the most common conditions, or conditions that contribute to the most deaths, would be focused on, and interventions and resources would be invested strictly in these conditions. The scope of such an approach is usually planned in 5-10 year increments. A comprehensive approach conversely addresses a broad range of conditions and services. Often a comprehensive approach is very expensive, with a long time horizon, and is often out of the reach of many low-income countries until they achieve greater overall development. Despite these two approaches, there are common elements for both, which Prof. Bradley presented.

Prof. Bradley presented a framework for analyzing primary health care delivery capacity in a diagram that consisted of six different “buckets” that are common elements among all primary care systems:

- Service package
- Organization and management
- Financing and payment
- Community engagement and education
- Public policy to support health
- How the system learns/improves/adapts over time

She noted that the answer to finding the right organization of these elements will depend on the unique economic, political and cultural context in a country, as well as priorities of the leadership. The buckets are intended to all be interconnected, not necessarily organized in a sequential or linear manner. Additionally, the development of the framework, and the way a country chooses to organize the buckets will be an iterative process and the rate at which these buckets develop will vary depending on the context. An important point of discussion was where ‘people’ fit into these buckets. Prof. Bradley clarified that there will be people in different roles in each of the buckets, depending on whether they are providers, patients, managers, etc. Prof. Bradley explored each of the “buckets” in greater detail below.
Service Package
In discussing the service package, Prof. Bradley articulated that in terms of comprehensiveness, the package could range from basic to very comprehensive, which will vary by level of development. A decision has to be made whether to invest more in preventative services or in more curative services, each having financial implications.

Organization and Management
In discussing organization and management, Prof. Bradley explained that a lot of issues regarding the health workforce would belong in this bucket. The reporting relationships and organizational design would also be here, as well as planning for professional career paths. Lastly in this bucket are management systems; information systems, human resource systems, supply chain and referral systems, and other management systems needed to implement the primary care system strategy.

Payment and Financing
The payment and financing bucket includes raising money for health services – how much comes from donors, government, external sources, etc. It also pertains to spending money – paying for services, private out of pocket, and insurance based. This bucket includes how hospitals and physicians are paid, such as fee for services, capitation, salary, etc.

Community Engagement
This bucket could include community level boards, mobilizing community to sustain their own health, and deciding whether to design the health system around users, or around a geographic area.

Public Policy to Support Health
Public policy consists of things like the interactions between Ministry of Health staff with other ministries, and whether a strategic approach to these interactions exists so that other ministries are also producing health through their investments. An important element of public policy is how much a country prioritizes health, not just health care.

How the System Learns
System learning occurs both from within and from the outside. Learning from within is achieved through things like national and regional data monitoring systems, dashboard indicators, valid reporting, and a mindset to make decisions based on data. Learning from the outside occurs through engagement with international partners, collaboration, and learning exchange.

Following Prof. Bradley’s presentation was a very active discussion about the service package, workforce development, focusing on outcomes, and how to leverage decisions to support good health outcomes, among other topics.
Session 4: Brazil Case Study

Dr. Luis Sampaio, Strategic Information and Corporate Development Advisor at Unimed BH, and Former National Chief Director in the Department of Primary Care, Brazilian Ministry of Health

In Brazil, primary care is understood to be a key component of the health care system, and includes comprehensive health care, health promotion, prevention, inter-sectorality, social determinants of health, and community participation and empowerment. It is a network of services that must work together. The primary care system is part of the public system, however there is also a strong private health sector.

History
In the 1980s there was a ‘Sanitary Reform’, followed by health becoming a constitutional right in Brazil in 1988 with the creation of the Unified Health System. This was intended to add social security for the population of Brazil. There were two health laws passed, the first being the General Directions in 1990, followed by the Social Control and Finances law in late 1990. The central purpose was to provide free, accessible health care of high quality, to every citizen of Brazil.

Preliminary Step: Community Health Worker Program (early 1990s)
The preliminary step in primary health care reform in the early 1990s was the Community Health Worker Program, which was supervised by well-trained nurses who had 5 years of university coursework. This program was in geographically delimited areas, and enrolled families in a comprehensive approach. There was generalist training in key priority areas contracted by “paymasters”. These were institutions that were paid.

Step One: Beginning of National Program (1994)
In 1994 the national program began. This involved the introduction of the Family Health Program (FHP) in rural and urban areas. In the beginning, a fee-for-service model was used. However after a year and a half it was determined that this was not working, so they revised the finance strategy. They started paying the municipalities based on the number of Family Health Teams (FHTs). The Primary Care Organization Manual was developed, which set out how to organize the FHTs and how the teams should work, as well as providing standards for facilities. This manual was flexible and adaptive but served as a guide. The National Data System for Primary Care was instituted and primary health care (PHC) national indicators were developed to be able to report on the big national indicators. There was also a Capacity Building University Strategy developed. The government called on universities to work with the PHC program, which ended up being one of the most challenging elements. Family medicine was not a specialty in medical schools in Brazil at that time; this specialty was only recognized by the College of Physicians in 2002. Thus, it was a difficult transition to make to integrate a family medicine curriculum into the medical schools. The Brazilian government implemented a
National Communication Strategy to communicate with people and communities about the program - demonstrating the importance of transparency and participation in this program.

**Step Two: Conversion to Family Health Approach (2000-2006)**
The second step, starting in 2000, was the conversion of the traditional model to the Family Health approach. In 2001 there was an increase in municipalities' budgets with higher coverage by the FHP; serving as an incentive to adopt this model. In 2002, the Family Health Strategy Expansion Project (PROESF), funded by the World Bank, was implemented in large cities. Equity incentives were established in 2004, in which municipalities with a human development index (HDI) < 0.70 received 50% more funds for implementing the FHP. In 2006, the National Policy of Primary Health Care passed, which is how the program became a political strategy for the whole country. Before this it was a “program”, implemented discretely in different areas; but after this policy was passed, it became a national strategy. This policy replaced 30 previous Ministerial resolutions.

**Step 3: Formation of Health Networks (2007)**
The third step, in 2007, was the formation of health networks with FHTs as a point of entry and follow-up. The Health Coordinated Network Territories were implemented, where FHTs worked together with social determinants of health teams and family health support teams. Additionally, inter-sectoral programs were developed. Jointly funded, the FHT worked together with other ministerial programs including the Ministry of Justice, Ministry of Education, Ministry of Social Development, Ministry of Defense, Ministry of Agrarian Development, and Ministry of Culture. These joint initiatives were an important moment in the development of the FHP.

**Step 4: Flexibility in FHT Composition (2011)**
The most recent steps taken in 2011 were creating flexibility in the team’s composition, altering the payment structure, and creating more stringent evaluation of FHT performance. While initially all members of the FHT worked full time, now some teams have half-time doctors. New performance payment approach data is being proposed. The FHT started with payments based on structure and process, but is now moving towards paying based on outcomes. Another development, which is controversial, is the plan to implement an external evaluation of the FHTs. Teams will be evaluated, and based on the results of the evaluation, different teams will be paid differently depending on performance. Already, there are teams that have been dissolved due to poor performance – about 500 each year. Some teams, when they lose a member of the team have difficulty continuing to perform high-quality work. In the new system, if the teams are not functioning well, then the government will not pay them and the team will be withdrawn from the system. The outcomes of the previous evaluations have been published in the American Journal of Public Health and the Lancet, showing the results of the program.

**Family Health Program Coverage**
Brazil is composed of 27 states, and 5,562 municipalities. There was a lot of expansion in coverage of health services between 1994 and 2012, where presently the entire country has health services. There are now 33,000 teams covering 52% of the population. The decision of
states to enter into the national policy was made at the request from the federal government, however, states had the autonomy to join or not. Three states decided not to join the national policy for a decade, which resulted in low coverage of primary care in these states.

**Responsible of the Federal Government**
The federal government established guidelines for primary care and sets up critical areas that the government had to follow up on nationally. At the beginning there were 6 priority areas, which has since expanded to 14 at the national level. These strategic areas include the health of women, children and seniors, chronic diseases such as hypertension and diabetes, tuberculosis, leprosy, oral health and eradication of children malnutrition.

The federal government finances 50% of the PHC system, coordinates human resources for health, and works with the universities. With a decentralized system, the municipalities generally have no power to negotiate with universities regarding training family health doctors, thus this is done at the federal and state levels. The federal government also proposes mechanisms for PHC programming, regulation, control and evaluation, and monitors and follows up on national health indicators.

**State Responsibilities**
The states are responsible for monitoring the implementation and execution of PHC actions in their territory, regulating relations between municipalities (such as transferring clinicians as needed), coordinating the development and execution of human resources, qualification policies for providers in their territory, co-financing PHC actions, and supporting PHC evaluation.

**Municipal Responsibilities**
The municipal level is responsible for delivering care to the user. There are no federal or state health units; all of these were transferred to the municipals in the 1990s. There used to be federal, state and municipal health centers caring for patients, but these were unified under the municipality. The municipal level is responsible for defining and implementing the PHC model in its territory, managing PHC labor contracts and working conditions (public-private partnerships in some cases), developing and maintaining PHC infrastructure and equipment, co-financing PHC actions through municipal taxation (45% of financing comes from the municipality), inputting data into the national health information system, evaluating the performance of FHT under its supervision, and integrating the FHTs into the health services network. Almost 100% of the PHC facilities in the public system are publicly owned and operated by the municipal government (or transferred from the federal or state to municipal government during decentralization). Public private partnerships (PPPs) are restricted to large cities like Sao Paulo and Rio de Janeiro.

**Shifts from the Previous Model**
When the health care reforms took place, Brazil moved from a passive approach to a proactive approach to providing care. FHTs now engage with the community and discuss their needs for improving their health. Unlike the previous model, FHTs are familiar with the households they are responsible for in the area they serve. The FHT has ties with the community, and they have
the participation of the community in their endeavors. National and state conferences on health are held every four years in order to share information across regions, and the FHTs bring suggestions from the communities to the national level during these meetings. The last primary care exhibition had 7,000 people attending.

**Service Provision and Composition of the Family Health Team**
Each FHT is composed of at least one physician, one nurse, a nurse’s assistant, and 4-6 community health agents (more required for low-density areas). Most teams also have a dentist. Each team is assigned to 2,400 to 4,000 people in a geographically defined territory. Initially, FHTs were responsibly for up to 4,500 people; however it was reduced because they were unable to provide adequate care for this population.

FHTs work together on clinical, public health, health promotion, and social issues. They enroll and monitor the health status of their defined populations, provide PHC, and make referrals to higher levels of care. Teams must visit households, but also have a base unit they work out of. Additionally, they have to understand social processes and conditions in their catchment areas and participate in local health councils. There are now nationally standardized activities of health promotion, public health, and primary medical care with single governance of the providers.

**Role of the Community Health Agent**
As mentioned above, there are generally 4-6 community health agents in each FHT. The Community health agents live in the same area where they work, and thus know their community’s problems. They facilitate and improve the connection between the primary care professionals and the community (cultural competency), and are considered core members of the Brazilian PHC program. Not only do community health agents focus on illness and programmatic activities, but are also a general health and social professional as well as community activist.

**FHT Hours and Compensation**
All teams work full time, 8 hours a day. As of 2011, some doctors work half time, which is a controversial issue since the rest of the FHT has to work full time. Generally, salaries have been competitive for members of the FHT. For example, for a physician, salaries are equivalent to having two or three different part-time jobs (which is what most previously did), and doctors prefer working just at one location. However, the situation of compensation has deteriorated lately due to issues of inflation and stagnant budget growth - steering the government to negotiate salaries.

**The Benefits Package**
The PHC benefits package has evolved over time, starting with 6 priority areas, and expanding to the current 14 priority areas below.

1. Women's health (pre-natal care, prevention of cervical cancer, family planning)
2. Child health (growth & develop, nutrition, immunization, treatment of prevalent illnesses)
3. Control of hypertension
4. Control of diabetes
5. Control of tuberculosis
6. Elimination of leprosy
7. Oral health
8. Seniors’ health
9. Health promotion activities
10. Prevention of, testing and counseling re: Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs) – specific program
11. Mental Health – specific program
12. Public Health and health promotion activities
13. Small procedures
14. Acute care

Data was generated from a national survey in 2001 and 2008 of 14,000 FHTs surveyed on what was actually happening in the field. While in theory all of teams have to implement all of the priority areas above, in reality some teams are not doing some activities.

Financing
The Brazilian primary care system costs about $50-$60 United States Dollar (USD) per capita per year (~10-12 billion USD for approximately 191 million people), with major expansion during the last 15 years; 48% of the health care expenditures nationally are from public sources and the remainder is from private sources.

The federal government transfers money to the municipalities for provision of services, and some to the states to support the universities and to help with monitoring and developing indicators. About 20 out of the 27 states transfer money to the municipalities as well, but it is at a much lower level than transfers from the federal government. There are also intra-municipal funding pools, which transfer money from the municipality to institutions and individual professionals. There are two exceptions to this financing structure: 1) the federal government pays scholarships directly to professionals and teams; 2) there are also state payments to professionals if the state contracts doctors to provide services in another municipality that has insufficient doctors.

User Fees
With regards to user fees, they are not required in public facilities. Additionally, there are no informal payments reported in PHC facilities (though there have been some reported in hospitals). As of the last 3 years some municipalities are starting to use performance-based payments.

Financial Incentives and Transfers
There are a number of financial incentives transferred from the Federal government to the municipalities. There is a per capita fixed amount, a per capita variable amount, and a fixed amount for each FHT for implementation. The Federal government also pays the minimum
wage for the Community Health Agents. The Federal government gives a 50% increase in funding to municipalities with low human development indexes and areas with vulnerable populations, such as indigenous populations, because these areas are more difficult to work in and require greater resources to reach dispersed populations. Five percent of the total funds is dispensed by the federal government to the states to balance their budgets, with criteria defined by each state.

There are also incentives to renovate and built new PHC facilities based on coverage, incentives for other programs and investments connected to FHT implementation. There is a loan from the World Bank (for the PROESF project) to develop and test new performance tools and to implement PROGRAB (performance management tool for teams) and AMQ (quality improvement tool).

**Demand-Side Incentives**

On the demand side, there are conditional cash transfers (CCT) for families, though these are not exclusively for health. The Brazilian CCT system transfers money to 40 million people, which is 20% of the population of the entire country. Examples of the conditions that must be met relating to health to receive a transfer are utilizing prenatal care and vaccination. The FHT closely follows recipients of these conditional transfers because these are poor and vulnerable populations and thus tend to have lower access to health care services. There are also cash payments to patients, which are very controversial. For example, select patients can get some money if they go for prenatal care or other specialty care.

**Supply-Side Incentives**

On the supply side, there are transfers to sub-national levels of the government, cash transfers from federal to states and municipalities, and cash transfers from states to municipalities. There are also investment cash rewards to municipalities based on performance (coverage and outcome indicators).

**Provider Incentives**

Providers receive salary increases when they move from the traditional health care model to a FHT. There are performance bonuses for teams from the municipality, scholarships from the Federal government for professionals who serve as tutors, as well as prizes at national, state and municipal exhibitions and contest. This is to get providers to participate in these events and discussions. Sometimes prizes include trips to visit other countries to see their PHC system in action.

**Challenges**

While there have been great achievements made through the development of the Family Health Program, there remain several challenges that need to be addressed.

1. **Health care** - Horizontal integration of vertical programs at the local level, including traditional public health programs and health promotion aligned with the clients. Sometimes the programmatic areas want to do things without involving teams, but this causes duplication.
2. **Governance** - Defined responsibilities for each government level in PHC management in a poor decentralized capacity environment. How you manage a system with over 5500 municipalities is a big challenge. They are growing the capacity to manage, but management continues to be a challenge.

3. **Human Resources** – The change to the educational approach for health professionals (undergraduate, onsite training and so on) has been challenging. There are still no family medicine departments in the medical schools, so the universities are graduating specialists, when they really need primary care doctors. The government is giving money to universities to create departments of primary care, but this is still in progress.

4. **Financing** – The earmarked budget provisions for PHC from the government overlap with the services provided by the private sector for the middle and upper income populations. Currently, the new middle class in Brazil have power to buy; their priorities are first to buy a house and then to buy a private health care plan. There are a lot of people who are overlapping private and public coverage, which results in greater spending than is necessary. Although, people should not be utilizing both, it is becoming more common.

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**Session 5: Estonia Case Study**

*Margus Lember, Professor, Department of Internal Medicine, University of Tartu, Estonia*

**Background on Estonia**

Estonia is a relatively small, high-income country of about 1.3 million people spread over 45,227 km². The demographic make-up of the population is 15% 0-14 year olds, and 17% 65+. The gross domestic product (GDP) of Estonia is $19,800 USD, which has increased rapidly from $6,278 USD in 1995. Spending on health is $1,294 USD per person, which is about 6.3% of GDP. The Estonian primary care system costs an estimated $200-$250 USD per capita per year (this is around 18% of $1,294 per capita for all health care expenses annually). Estonia’s human development index (HDI) is ranked 40 th in the world, its infant mortality rate is 3.6, and life expectancy is 79 for women and 69 for men.

**Human Resources for Health**

In terms of human resources for health, there are 34 doctors, 68 nurses and 6.2 general practitioners per 10,000 people. Currently, Estonia is not producing enough doctors to maintain these numbers given the number of doctors aging out of the work force. There has been a decrease in hospital beds, from 968/100,000 in 1992 to 572/100,000 in 2008, as well as a decrease in the average stay in hospitals from 17.6 days in 1992 to 7.9 in 2008. Although the number of beds per hospital is sufficient, there needs to be more hospitals. The system is physician-centric; however, each physician has also a family nurse. Community health workers are not used in this system.
Estonia has been developing its primary care system since the Ministerial decree in 1997 and has seen improvements in many health outcomes. However, the ability to attribute the improvements to the changes in the health system is limited because overall economic development has occurred at the same time.

**Health Reform**
Starting in the early 1990’s there were three major changes in the health system:

1. **Health insurance was introduced**
   Health insurance in Estonia became a public compulsory health insurance system. One organized government insurance plan was created, with no competition. There is funding from a special tax that goes specifically towards this insurance.

2. **Primary care Family Doctors were created with independent practices**
   Previously, there were polyclinics with many specialists available and a parallel structure. Now, Family Doctors can run their own clinics.

3. **There were hospital ownership reforms**
   Hospital reforms were made at the secondary care level, and hospitals merged.

International learning and policy diffusion were critical parts of the early reforms. The changes in the primary care system were brought on by several problems with the existing primary care system; namely, low efficiency, lack of coordination, low comprehensiveness, questionable continuity, divided responsibility and dissatisfaction among the population and providers. To come up with solutions to these problems, Estonia collaborated with other countries, particularly Finland, to do a comparison with their health care system. When comparing the scope of services between the two countries, they compared the district doctors in Estonia to general practitioners in Finland, and noted that Estonia’s district doctors had limited clinical areas, limited procedural activity, rigid work organization, parallel services, no financial responsibility and no freedom to organize their own practices since they were all employed by polyclinics. In addition to the cross-country comparison study, there was international cooperation, including with the WHO (which created a course in Tampere in 1989), with the New Leuwenhorst Group in Tartu in 1990, and with contacts within WONCA (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians).

**Favorable Environment for Change**
There was a favorable situation in the early 1990s that contributed to health reforms taking place. The primary care doctors were really the ones who initiated the changes, as they saw a possibility for primary medicine to be established as a discipline. At the time, it was not popular among district doctors to work at the polyclinics; they preferred to work in the hospitals. The district doctors wanted to improve their practice, to take on more responsibility, and to get more power within the health care system. Similarly, specialists felt that improving the quality of primary care provided by the district doctors would enable them to perform ‘real specialists’ work. Additionally, the population favored this change, because they were dissatisfied with the current system, and saw a possibility to create an alternative system. Finally, politicians
believed reforms could create better control of rising health care costs, and were thus attracted by the novelty of the idea. They anticipated rising health care costs would accompany the economic growth the country was experiencing, along with the rising markets and opening up of the borders to be part of the world community. They wanted to create a more cost-effective primary health care system, which would allow for further development of the secondary health care system. In addition, being on board with reforms was a way to garner votes, though in the early 1990s health care was not a big issue during elections.

**Training and Retraining Family Doctors**

Once there was consensus to shift to a model of primary care doctors, the question became how to get the first cohort primary care doctors into the health system? There were some discussions about importing doctors from the UK, but more serious dialogue was about changing the medical education system. Significant changes were made to the standard medical education; namely, undergraduate medical specialization was abolished. Under the Soviet system, undergraduates could specialize in pediatrics, obstetrics and gynecology, etc.; however this was ended. The new medical curriculum consisted of the same 6 years of undergraduate studies for all medical students, followed by post-graduate specialization. Family Medicine was recognized as one of the post-graduate specialty areas in the 1990s.

Training only new, young primary care doctors was an issue since the system they were entering into was still unchanged. Therefore it was agreed that, in addition to changing the medical school system, practicing doctors would need to be retrained in order to create a more uniform change among health care providers currently practicing. Doctors that were willing, who had already specialized in a different area of care, underwent retraining in primary care. Collaboration with the universities was a challenge as the Family Doctor educational pathway was new. However, the government worked closely with the universities to create a 3-year retraining program, producing certified Family Doctors.

**Timeline**

1991: Postgraduate training of Family Doctors; Society of Family Doctors founded, curriculum change at the universities by bringing together experienced doctors with existing medical faculty to design new curriculum. There was in-service training for 3 years for existing doctors, who would take courses while continuing to practice.

1992: There was a change of funding of health care to government insurance and the Department of Family Medicine at the University of Tartu was created.

1993: Ministerial decree made the Family Doctor profession a specialty, after the first cohort of doctors were trained.

1995: Estonia/World Bank Health Project was launched, the main objective of which was to have new medical buildings built, and also incorporate public health. Limited resources were provided by the government at this point. However, an increasingly number of people from other countries came to Estonia and inquired about their primary health
care reforms, which put pressure on the government. Estonian Society of Family Doctors became a full member of WONCA.

1994-96: Unsuccessful preparation of Family Doctor`s law, though there continued to be training and retraining for primary care doctors.

1997: A Ministerial decree passed with the purpose of creating as simple and understandable a primary care system as possible at the beginning. This included creating a family medicine practice with a list system, where each person in the entire population was listed under a specific Family Doctor. The population was given the opportunity to decide who they wanted as their Family Doctor, and about 63% of the population did so, with the remainder allocated according to where they lived. They also had the right to change doctors if they wanted.

There were a fixed number of practices with a set number of doctors in each, based on population needs. The Family Doctor became an independent contractor, who contracted directly with the health insurance provider. Often the doctors continued to practice in the same buildings they had previously, but being able to contract independently had a major effect on the distribution of power. Control no longer sat with the head of the polyclinics; the doctors could negotiate directly with insurers about services and payment.

Family Doctors started being paid with a combination of the basic pay (10% of their compensation), capitation (70% of their compensation), fee-for-service (around 15% of their compensation), and a bonus based on performance (roughly 5% of their compensation). The task descriptions of Family Doctors were detailed, including a partial gatekeeping role. They also receive bonuses for working in rural practices, secondary care consultations, etc. For the doctors who were certified as Family Doctors, they received more funding than those who were not certified, and the discrepancy in salary served as a motivator to get existing doctors retrained as Family Doctors. Because Estonia was trying to encourage growth in the number of Family Doctor, their compensation was set higher than the compensation of specialists, who are salaried in hospitals.

Almost all Family Doctors are female, while hospital physicians are typically male; 56% of Family Doctors work in group practices. Currently, the model appears to work better in rural than urban settings.


2004: Finished retraining all primary care doctors. Between 1991 and 2011, 1147 Family Doctors were trained and retrained.
Session 6: Sri Lanka Case Study

Palitha Mahipala, Additional Secretary of Medical Services in the Sri Lankan Ministry of Health

Sri Lanka has a pluralistic health care system, consisting of indigenous practices, Ayurveda and allopathic medicine. Health is considered a fundamental human right, and is in Article 27 of the Sri Lankan Constitution. The development of the public and primary care in Sri Lanka has a very long history, dating back to the 4th century BC, with the appointment of sanitation workers to clean the streets. The Civil Medical Department dates back to 1858, and established civil hospitals, district and immigration hospitals, dispensaries, a leper asylum and a mental asylum.

Reforms that led to the current primary care system began in 1952 with Act No. 12, which formed the Department of Medical and Sanitary Services. This was closely followed by the initiation of the Family Planning Association in 1953, decentralization of the Department of Health Services in 1954, the introduction of immunization with DPT in 1961 and the eradication of smallpox in 1979. There was a strong focus on immunization between 1962 and 1995, with universal child immunization in 1989, and national immunization days initiated in 1995. In 1992, a Presidential Task Force was appointed to formulate a National Health Policy.

Summary of Health System Features
The following elements are important components of the Sri Lankan public health system that capture the overall structure of the system:

- System provides preventive, promotional and basic curative services
- Composed of both government and private systems
- Government system provides all care “free of charge at the point of delivery”
- Government system has a preventive/community health service based on health areas (defined geographical areas and populations – provides domiciliary and clinic care, and targeted interventions in identified communities – schools, workplaces, etc.)
- The Government system has a curative care system which provides institutional care – both outpatient and hospitalized care
- Decentralized system – Primary level services come under the Provincial Health Authorities
- Central Ministry of Health gives policy and strategic guidance

Curative and Preventive Government Services
Two distinct services delivery systems exist within the Government system, a curative care system and a preventive care system.

Curative care is provided through a network of 958 health institutions. Divisional hospitals provide inpatient and outpatient care, and approximately 930 primary medical care units provide outpatient care including basic emergency care. This system provides free primary curative care to all. All curative institutions at the primary level have Medical Officers. Within
the curative care system, the institution catchment area is not defined, allowing patients to access care based on need.

**Preventive care** is provided through a health unit system where a Medical Officer of Health (MOH) is in charge of a defined population that varies from 20,000-150,000 people depending on local government administration boundaries. A health team of Public Health Inspectors, Public Health Nursing Sisters, and Public Health Midwives assist the MOH. Preventive care is provided through both institutional and home-based care with defined boundaries in terms of the population covered. The main focus is on maternal and child health as well as communicable diseases.

**Service Package**
There are 17 priority areas for the primary care system identified by the Sri Lankan government:

1. Proper and adequate nutrition
2. Safe water
3. Basic sanitation and hygiene
4. Maternal care
5. Child care
6. Family planning
7. Immunization
8. Prevention and control of common communicable diseases
9. Prevention and control of common non-communicable diseases
10. Appropriate and early management of common minor ailments and emergencies
11. Simple rehabilitation
12. Mental health
13. School health
14. Oral health
15. Occupational health
16. Prevention of blindness and visual impairments
17. Health education and community organization for PHC

**Organization of the Primary Care System**
The primary health care delivery and support system is diagramed below. The Gramodaya Health Centres are the first point of contact for primary health care.
Primary Care Team
The country is divided into 300 Health areas (known as MOH areas) each with 50,000-100,000 people. Each MOH area is managed by the Medical Officer of Health and has a team comprised of a MOH, Dental surgeon, Public Health Inspector, Public Health Nurse Assistant, Public Health Midwife, School Dental Therapist, Field Assistants, and Health Volunteers (1 per 25 household). Community volunteers assist the MOH team in fieldwork.

Primary Care Institutions
The primary level curative care institutions consist of Divisional Hospitals, which provide both inpatient and outpatient care (district hospitals, peripheral units, and rural hospitals) as well as Primary Medical Care Units, which provide only outpatient care (central dispensary and maternity home, and central dispensaries). These have recently been upgraded to provide basic emergency care as well. All people have access to a facility within 3 kilometers. Lifetime modification clinics are emerging as chronic diseases are becoming more common in Sri Lanka. These clinics work on lifestyle issues that may contribute to poor health with the goal of preventing and managing chronic diseases.

Prevention Focused on Maternal and Child Health and Communicable Disease
As mentioned previously, the focus of the preventive services provided by the government is on maternal and child health and communicable disease.

Maternal and Child Health
There is a continuum of maternal care services provided through an integrated package at the community, clinic and institutional levels. The service continuum includes family planning and reproductive health services, through to post-natal care.
The Public Health Midwife (PHM) is the front line health worker providing maternal and child health care. The PHM is trained for one and a half years, with the first year of training in a nurse’s training school, and the following 6 months of training at a field training center. They are responsible for a population ranging from 3,000 – 5,000 in a well-demarcated area. They work according to a planned program, and provide skilled assistance in the field.

There is also a Safe Motherhood Team, which is organized around the mother and family and is composed of the primary care team, an anesthetist team, an intensive care unit/high dependency team, a neonatology team, a Comprehensive Emergency Obstetric Care (CEmOC) team, and a Coordinator of Maternal and Child Health. As a result of the Government of Sri Lanka’s (GoSL) focus on safe motherhood, 98% of deliveries are in institutions (94% government, 4% private), and 75% are in facilities with CEmOC services available. Due to promotion of breastfeeding, 82% of babies are still breastfed at 4 months. Seventy percent of mothers receive at least 1 post-partum visit by a PHM. Maternal deaths have been cut in half just since 1995, dropping from 61 deaths/100,000 live births in 1995 to 31.6 deaths/100,000 live births in 2010; far lower than the average in Asia (190/100,000 live births).

**Strengths of the Maternal and Child Health Services**

An important driver of change in the approach to maternal health services was the maternal death reviews. The results of this review brought attention to the issue and caused a change in attitudes among all levels of health workers. The reforms to improve care were a collective effort. There was a participatory approach without faultfinding, which resulted in shared responsibility, improved compliance, participation and quality of data. Additionally, a strong involvement of professional bodies improved participation and implementation of follow up activities. Reforms capitalized on the strong maternal and child health (MCH) service delivery system and were reinforced by data captured in the Health Management Information System (HMIS). Maternal death reviews thus became a routine activity in the MCH monitoring and evaluation system. Reforms also addressed health inequality by identifying inter‐district disparities and related issues. As a “bonus” outcome, the achievements in maternal health motivated policy makers and development partners (eg. UN agencies) to allocate further resources to MCH.

**Communicable Disease Prevention**

The second focus of the preventive care system is prevention of communicable diseases. The focus of this area is the expansion of childhood vaccination for preventable diseases, which have increased dramatically from the mid-1900’s to 2010. Due to the focus on immunization, Sri Lanka is now one of the strongest performers in the region and in the world. Ten diseases covered by vaccination have been controlled and the majority have reached the elimination levels.

Contributors to this success has been maintaining the potency of vaccines through a well-managed cold chain system, access to known high-quality vaccines for the total population at the lowest possible cost, a sensitive AEFI (adverse events following immunization) surveillance system, and a secure financial allocation for vaccination made by a separate vote in the national
budget. As a result of these factors, in 2010 immunization coverage for 8 childhood immunizations was between 92-97%.

In order to achieve the political will to prioritize prevention of communicable diseases, there is very participatory decision making, involving the Director General of Health Services, the Deputy Director General, the Chief Epidemiologist and the Secretary and Chairperson of the National Advisory Committee on Communicable Diseases (NACCD), which is the entity that recommends the introduction of new vaccines. There is an Annual Immunization Stakeholders Forum, and members of the NACCD meet every quarter to discuss recommendations. There is strong utilization of disease surveillance built into decision making, so having a strong surveillance system is of utmost importance.

Health Care Financing

Health care services are provided free of charge to the population, paid for by the Ministry of Health, Government of Sri Lanka. Over the last several years, the budget devoted to provision of care has been steadily increasing. All levels of care, from basic (immunizations) through complex (bypass surgery) are performed free of charge.

There are three priority areas that focus on leveraging health care financing to produce more equitable access to services:

1. Universal accessibility to available resources and services in order to provide adequate coverage of important health needs
2. Securing additional resources for health, reallocating existing health and social resources to those whose needs are greatest
3. Reducing the gap between those who have access to an appropriate level of health care and those who do not

While all services are provided free of charge, there is relatively low government spending on health, and there has been a steady reduction in the Government’s contribution to health since 2006. In 2009, the per capita total government health expenditure was $58 USD, and as of 2012 the government expenditure was 1.4% of GDP. The average household spends 3% of their monthly income on health. Other sources of financing include private health insurance (2%), social health insurance (for government and semi-government employees) (<1%), and donor funding (<5%). While Government expenditure has been decreasing, out-of-pocket expenditure has been increasing, and outpatient care utilization has been decreasing. Currently, the GoSL’s key emphasis is on economic development and infrastructure development including roads, bridges, electricity, water, and power projects. While these changes may indirectly impact health outcomes, the investment is having the consequence of reducing investment directly in health.

Reflecting generally on financing progress to date, Dr. Mahipala proposed that the general tax based health financing has shown good results up to now and should be kept in place. The overall Government contribution however has been inadequate. If additional investment were
made, key areas to focus on are further strengthening primary care and providing essential drugs at primary level curative institutions. Also, retention of human resources in rural areas has been a challenge and offering more incentives could help. One way to finance health care for the segment of the population that can afford it is to expand private insurance.

**Community Participation, Individual Involvement and Self-reliance**

The Sri Lankan health system is very people-centered. People and communities are empowered for greater self-reliance and more active and responsible involvement in improving their own health. Rather than a passive approach to improvement of health status of the population by simply delivering health services, it is expected that the population is actively engaged in improving their health.

There are two important aspects to social mobilization for health:

1. Political commitment for community participation through decentralization of decision-making
2. Individuals must realize their potential for self-reliance through personal responsibility for their own family’s health - adopting changes in behaviors, life style, controlling their social and physical environment.

**Inter-sectoral Coordination**

It is recognized that there are several elements of society that affect health outcomes, including availability of land and food, existence and accessibility of social infrastructure and services such as water, schools, transport and health facilities and level of literacy particularly of women. Thus, there is a lot of attention paid to inter-sectoral collaboration to enhance health outcomes.

**Areas for Continued Reform**

The primary care services structure needs to change to provide universal access to health services. Two decades ago, the GoSL made a policy decision to strengthen specialized care, which resulted in expansion of specialist level hospitals, making them bigger and better. Currently specialists also serve as primary care providers. This has attracted people to larger facilities, bypassing of the primary level facilities resulting in underutilization.

Moving forward, the GoSL wants to strengthen access to primary care by further strengthening the existing system to provide care based on the epidemiological and socio-demographic needs.

They have developed eight strategies aimed at achieving this:

1) Improve accessibility to appropriate primary level care
2) Ensuring continuity of care
3) Being responsive to individual and community health needs
4) De-institutionalizing primary care and promoting community care
5) Fostering other sector involvement
6) Accommodating home -based care
7) Supporting self-management (health literacy)
8) Continuous quality improvement and patient safety

In order to achieve the above strategies, a series of pilot interventions are being tested for feasibility and effectiveness.

- Re-organize the outpatient services in the primary level institutions
- Competency building to adopt the Family Medicine approach by the curative health care team
- Use of customized WHO Package of Essential Noncommunicable Disease Protocols – risk prediction, life style guidance, health check-ups, treatment and follow up
- Community awareness to promote health seeking behaviour
- Increase male participation in-screening
- Basic emergency care and standard protocols for care
- Referral and back referral
- Introduce a Personal Health record for those above 35 years (subsequently will cover all)
- Competency building of curative and community staff on effective linking between the two teams, community mobilization and community empowerment, joint monitoring between curative and community teams
- Improve infrastructure, availability of essential drugs for management of non-communicable diseases and other common conditions
- Improve health staff accommodation facilities in rural areas
- Reorient undergraduate medical training on primary care using family medicine principles

Session 7: Ethiopia Case Study

Keseteberhan Admassu, State Minister of Health, Ethiopian Federal Ministry of Health

Background
Ethiopia has an estimated total population of 79.8 million in 2011 with a population growth rate of 2.6%. The total fertility rate is 4.8. Ethiopia has a highly decentralized Federal structure with nine regional states, two city administrations, 817 Woredas (Districts), and 15,000 villages or Kebeles.

History
Ethiopia had adopted Primary Health Care (PHC) as the national strategy around the late 1970’s.

At this time, the health system had a six-tier referral system introducing community health services in Health Posts (HP) at the bottom of the referral system. These HPs were staffed by trained Community Health Agents (CHA) and Trained Traditional Birth Attendants (TTBA). This approach was not sustainable because the CHA and TTBA were to be supported by the
community, since at that time they were not being paid by the government, but they were unpaid volunteers and thus demanding payment from patients to make up for a loss in wages. There was also a poor organization and management structure within the health sector; there was a national Ministry of Health (MoH) and a regional administration, but there was no administrative level below that. Because of the centralized administration, there was no support for primary health care staff.

There was a change in government in 1991, and the new government produced health policies focused on primary health care. Following the new health policy of 1993, the health sector had undergone many reforms. The referral system was reorganized and the management structure of the health sector changed considerably. The size of the MOH was reduced, giving more tasks and power to regional health bureaus (RHBs), and decentralization expanded to the district level where health service delivery was managed by woredas. The woredas were also responsible for budget allocation, hiring and firing. All of the vertical programs were integrated following the new policy of 1993, though some vertical programs, such as TB and malaria, were run with support from donors and multinational and multilateral organizations.

Ethiopia developed a 20-year roadmap, which was divided into 5-year segments, known as the Health Sector Development Program (HSDP). When the first health sector programs were reviewed it was discovered that needed services were not reaching some populations, and targets were not being met in areas such as vaccination coverage and family planning. A plan to expand facilities did not occur and there was unequal distribution of facilities, with urban areas having a disproportionate number of facilities while rural areas lack facilities. Due to these issues, there was a clear need to reform the health care delivery system.

The Flagship Program, or Health Extension Program (HEP), was conceived with the principle and philosophy that health is a product that can be produced by individuals and families. This mechanism was to be used to transfer responsibility to communities so they could start producing health themselves. As one example of this change, rather than having a vaccination program where health workers go out to rural areas and vaccinate en mass, within the HEP the approach is to educate mothers about the importance of vaccination so they demand services for their children themselves. The HEP was designed to create demand and empower individual families. In addition, it was recognized that the majority of the leading health problems in Ethiopia can be prevented by healthy behaviors and a healthy living environment. Thus, there was strong focus on creating hygienic environments and healthy behaviors.

Developing the HEP
There were five main steps that needed to be taken to develop the HEP. The first was creating a training program for health extension workers (HEWs). The CHAs from the 1970s and 1980s were no longer a part of the health system, so a new cadre of HEWs needed to be trained. Secondly, new HPs needed to be constructed. Third, a supply chain for medicines and drugs needed to be created. Fourth, there was a need to engage the communities, starting with the recruitment of HEWs through taking ownership of the program locally. Finally, they needed to
ensure that leadership was fully engaged in the process as well as the monitoring and evaluation mechanism of the HEP to ensure success of the program.

By design, all HEWs recruited were female, as it was expected that they would spend 75% of their time interacting with women and mothers in their homes. In Ethiopia, the women are the ones who are home during the day, so it was thought to be most culturally sensitive for the HEWs to be women. In addition, the government wanted to create a cadre of young women who were visible in their communities to serve as role models for young girls. It was envisaged that girls would see the HEWs as a model of another path they themselves could take, rather than the traditional path of getting married very young. The HEWs are amongst the highest paid individuals in the rural areas, so they were anticipated to be important role models.

Starting in 2004, 38,000 HEWs have been trained, only 400 of which are men. These men were trained because in some pastoralist communities females were not educated enough to enroll in the HEP program. Rural HEWs are high school graduates with one year of additional training, while the urban HEWs (referred to as urban health professionals) are registered nurses and 3 months of additional training. Of all HEWs, 34,000 are rural, and 4,000 are urban. The HEWs are supported by volunteer “model families”, which are families who have adopted a set of health and behavioral change interventions, and are recognized by the district office as model families in their community. For example, some of the interventions to be a model family are being fully immunized, receiving antenatal care and family planning, and building a latrine.

**HEW Responsibilities**
The responsibilities of the HEWs are to empower caretakers and produce model families, institutionalize and standardize “village” health care delivery linked to the Primary Health Care Unit, increase access and utilization of promotional, preventive, and essential curative care services, reduce opportunity cost for families, and enhance participation.

There are 16 HEP packages the HEWs are responsible for implementing in four different areas are:

**Disease Prevention & Control**
1. HIV/TB (tuberculosis)
2. Malaria
3. First Aid

**Hygiene and Environmental Health**
4. Personal Hygiene
5. Water and sanitation
6. Food hygiene
7. Latrine
8. Solid & liquid waste disposal
9. Housing construction
10. Insects & Rodents control
Family Health
   11. Maternal and Child Health
   12. Family Planning
   13. Immunization
   14. Nutrition
   15. Adolescent Health

Health Education and Communication
   16. Health Education and Communication

Starting in 2007 there was a radical sector-wide reform focused on the 6 building blocks below:

   1. Expanding health services
   2. Strengthening health workforce
   3. Putting in place an effective health information system
   4. Building a well-functioning health commodities supply and logistics system
   5. Sustainable health financing mechanisms
   6. Stronger governance structures

The Government used a reform tool referred to as the Business Process Reengineering tool to identify 8 core processes, and set up different agencies to address each. Following the reform, the health care delivery system was revised by introducing the primary hospital. The objective of these hospitals is to work in unison with the health centers and health posts to provide emergency surgical care.

The primary level of health care is now composed of a primary hospital, which serves 100,000 people, 4 health centers, each of which serve 35,000, and 20 health posts which serve 5,000 each. There are also general hospitals, which is the secondary level of care, and are supposed to serve 1 million people, and specialized referral hospitals (tertiary) which serve 5 million people.

**Health Management Information System**

An integrated reporting system and information dissemination system was created for performance monitoring and accountability purposes. Reporting includes reports on performance of the health sector, quarterly Health Bulletins “Policy and Practice” and statistical reports.

The annual planning cycle aligns with the Ministry of Finance, and is both a top down and bottom up planning process. There is a *woreda*-based planning process, using the Millennium Development Goal (MDG) 2 to identify the next steps, and try to sum up and identify priorities at the national level. The finance plan tries to align both vertically and horizontally.
Health Expenditures
The total health spending in 2007 was $1.2 billion USD, which was a 128% increase from $522 million in 2004. The per capita health expenditure is around $16.1 USD, which is up from $7.1 in 2004 and expected to continue to increase. However, it remains significantly below the $34 USD per capita spending recommended by the Commission for Macroeconomics and Health. Overall, the health expenditures are 37% out of pocket household expenditures, 21% paid by the government of Ethiopia, 2% paid by employers (parastatal and private) and 39% from foreign assistance. As Ethiopia develops towards becoming a middle-income country, it is possible that foreign assistance may decrease, and the Government hopes to create greater internal financing for health care moving forward.

Health Care Financing Reforms
Revenue Retention
There have been several health care financing reforms introduced, the most substantial being that hospitals and health centers now retain service charges and user fees. Revenue retention through charges and fees is the foundation for all health care financing reforms. It provides an incentive to facilities to control leakage and generate resources for quality improvements. There is also a fee waiver exemption program now where all services provided through the HEP are free of charge, select services at hospitals and health centers are exempted from payment, and there is also a fee waiver program for the poorest of the poor.

Hospital Autonomy
Another reform was that hospitals are now managed by boards, which decide internally on the allocation of resources. There are many advantages of decentralizing management authority in this way. Decisions made locally are based on better information about priorities and local needs, decision making will be faster as there will be no need to wait for central approval, there should be greater accountability as the board can monitor how funds are used and what’s being done to improve services, it may be easier to introduce fees or other financing arrangements, and there is more incentive with local retention of revenues.

Private Wing
The brain drain of high-quality physicians has been a serious problem in Ethiopia, with more Ethiopian doctors currently practicing in Chicago than in all of Ethiopia. In order to incentivize high-caliber physicians to continue practicing in Ethiopia, a private wing has been created within government facilities. In the private wing, doctors collect fee-for-service and can be paid up to 10 times the salary of doctors in public hospitals. Recently, regulations have been established regarding how the private wing can be managed, and the public hospitals are now actually experience a brain gain in the major cities, where doctors from the private sector and NGOs are now moving to public hospitals where they can practice in the private wing. Ethiopia is also combating the effects of the brain drain by increasing the number of doctors enrolling in medical school; this year there were 3,000 medical students enrolled.
Health Insurance
For people who have formal employment there is a social health insurance scheme being developed where employers will be mandated to have their employees covered. The intended goals of the health insurance scheme are to create a mechanism of mobilization and utilization of domestic resources, to pool and spread financial risks, avoid catastrophic health expenditures for users, promote equitable service delivery, achieve universal health care coverage, improve health service utilization, and to create sustainability within the health care sector. The health insurance agency that oversees social health insurance currently falls under the FMOH.

In reality, the majority of the population of Ethiopia is either self-employed or employed in the informal sector. For this population there is a community-based health insurance program being developed where the community shares the cost of health care. Families pay a certain amount of money each month, and the pool is used to cover people’s expenses. So far, preliminary findings demonstrate improved care and utilization rates, at the primary care level, where the community health insurance program is piloted.

Successes
Since implementing the HEP, access to primary care has increased tremendously, particularly for services like family planning, sanitation, and community case management of disease. Certain responsibilities have successfully been task-shifted to the HEWs. The coverage in services is showing national health impact, including on indicators relating to HIV, Malaria, TB, and under-5 mortality, which are all on a downward trend. The HEP is also helping with the empowerment of women, and the model families have been shown to be a very promising model for improving community participation and ownership.

Challenges
Quality of care
As the primary health facilities have been expanded in a short period of time and there was an increase in the level of low and mid-level health care workers (40,000 nurses, 5,000 health officers, 38,000 HEWs) the quality of care has been negatively affected. The priority is to now focus on quality of care – where the focus has been on the “hardware”, now there is a need to invest in the “software”.

Human Resources
There are human resource challenges in meeting the needs for higher-level health care workers, including radiographers, midwives, physicians.

Financing
Currently financing is very dependent on the international community, and there is a need to improve in-country utilization of resources.
The Supply Chain and Referral System
The supply chain and referral system have also proved to be challenging, since Ethiopia is a country 3 times the size of France with very limited access to road networks it is difficult to maintain a constant supply of medicines and commodities to every part of the country.

Session 8: Expert Panel Synthesizing Convening

Yogan Pillay, Deputy Director General of Strategic Health Programs at the Department of Health in South Africa
Michael Borowitz, Senior Health Economist at the Organization for Economic Cooperation and Development (OECD)
Ankit Kumar, Health Economist from the OECD
Somsak Chunharas, Director of the Health Systems Research Institute in Thailan.

Session 8 was a panel composed of four expert participants; Dr. Yogan Pillay, Deputy Director General of Strategic Health Programs at the Department of Health in South Africa, Dr. Michael Borowitz, Senior Health Economist at the Organization for Economic Cooperation and Development (OECD), Dr. Ankit Kumar, Health Economist from the OECD, and Dr. Somsak Chunharas, Director of the Health Systems Research Institute in Thailand. The purpose of the panel was to present lessons learned from the convening, focusing on what pathways to primary care have looked like, what we can learn from this process, and what we think primary care pathways should look like.

Dr. Pillay was the first to present. Dr. Pillay is currently re-engineering primary health care in South Africa. He highlighted the importance of context, and how the way people describe primary care depends on how they perceive the social, cultural, and historical context of their country. For example, Sri Lanka began the conversation on primary care dating back over 2000 years ago, with the inclusion of indigenous and Ayurvedic medicine. This is important, as Sri Lanka has truly has been on a health development continuum for the last couple of thousand years.

Dr. Pillay also noted that a common observation of the convening was that good quality case studies on the pathways to primary care are missing. We thus need to learn to develop case studies that are complex enough that they cover more than just highlights, but clear enough to be easily understood and relevant to other countries. To do this, documentation of process is critical, as is reflecting on what has been done.

The convening meeting raised as many questions as it answered. Below are some of the key questions Dr. Pillay presented that came out of the meeting:

1) Who needs the change in health, and how do you know when change is designed to be sustainable? A key element if you want to get significant change is to make sure you
know who all the players are, and whether they are lined up and in agreement about the proposed direction.

2) How do you develop adaptive leadership? We need good examples of how to encourage and grow adaptive, strategic leadership.

3) Is there a generic framework we can use to think about designing a primary health care system? A framework such as Prof. Bradley’s is a useful example of the kind of framework to “hang your coat on” while developing a health system.

4) How do you get radical change in a system that is already in place? How do you change the wheels of a car that is in motion? Identifying the levers of control and influence is a critical element of achieving this.

5) Coverage is a common measurement of success, but are there other ways to measure success or progress? For example, the most vulnerable often get lost in the desire to expand coverage. Similarly, it is important to maintain quality while expanding coverage.

Dr. Pillay noted a few key take home lessons learned from each country case study:

**Brazil:** The Brazilian case study was a good example of how federalism was able to achieve good PHC, particularly through the use of primary health care teams. The problem in the Brazilian system became how to keep high level doctors engaged, which is being achieved through utilizing the private sector.

**Estonia:** From Estonia, the relationship between the state and the university together with specialist groups was critical in the training and retraining of family doctors. Dr. Pillay raised the question of whether it is possible to take the lessons from a small country like Estonia where a single university was able to train most doctors without any major barriers, and apply it to a large country (like Ethiopia), where engagement of and alignment with stakeholders and universities would be more difficult.

**Sri Lanka:** Sri Lanka is unique in the fact that the prime minister chairs the national health council. This signifies the degree to which the country has prioritized health. Sri Lanka offers an example of health being established as a priority at the top level of government and being championed by a country leader. This gives the health sector leverage as compared with other sectors, and makes it possible to translate health goals at the top into real action. Sri Lanka is also an example of using a vertical program to move public health indicators forward.

**Ethiopia:** Dr. Pillay noted that Ethiopia’s stages of primary health care, starting pre-democracy during the regime of Haile Selassie and continuing through recent events, would make an excellent case study. He believes the Ethiopian case shows how change in the health sector can be sustained through political changes. The health extension worker model where HEWs
provide not only health education, but also tangible services such as family planning, also makes Ethiopia a very interesting case study.

The second panel expert to present was Dr. Michael Borowitz from the OECD, who presented with his colleague Ankit Kumar.

Dr. Borowitz shared the importance of being prepared for changes in demand on health services as a country develops. As a country develops and the population goes through the demographic transition the health system ends up being burdened by multiple chronic diseases that must be managed. Diseases like hypertension and cardiovascular disease become more prevalent and the system is faced with patients who have multiple concurrent morbidities that must be managed. Management of multiple morbidities becomes difficult when trying to apply a “siloed” system of care. It is thus important to look forward to what the future disease burden is going to look like in planning for the future a health system.

Dr. Borowitz presented an OECD analysis of how the structure and organization of a health system affects its outcomes. The OECD clustered countries in the analysis into five different groups. On one end of the spectrum were health systems that have a higher density of PC physicians relative to specialists, limited amounts of gatekeeping, use fee for services, and have doctors organized into solo practices. On the other end of the spectrum were countries like the UK where there is a good system of primary care, gatekeeping, doctors that are organized into group practices, and a lower density of physicians. In between these two ends is a spectrum of health systems. The results they found were slightly surprising and counter-intuitive; countries that were widely regarded as high-performers (based on outcomes) were countries that had a high density of primary care doctors and little gate keeping. Countries that were determined to be the lowest performers with poor outcomes had the lowest density of primary care physicians (including the UK). Further analysis showed that the density of PC physicians seemed to be the most important factor in predicting better outcomes when compared to other elements of the systems organization.

Finally, Dr. Borowitz offered Kyrgyzstan as an example of successful health care reform and discussed the various parts of the health system that were reorganized. The Kyrgyz organized multi-specialist group practices, with physicians, internists, OBGYNs and pediatricians working in groups. These mutli-specialist groups were paid through risk-adjusted capitation based on performance. There was open enrollment in both urban and rural areas, which created community engagement and participation. A new payment system for hospitals was introduced that was intended to create consolidation of hospitals and reduce hospital crowding, high occupancy, and long length of stay and encourage utilization of primary care units. They also improved the infrastructure of hospitals, made practices autonomous, introduced a program of advanced clinical training, created a family group practice association, and covered outpatient drugs. This combination of reforms proved to be successful. Dr. Borowitz noted, referring to Prof. Bradley’s framework, that if you don’t work simultaneously on all fronts of education, delivery, and financing you won’t be successful in reforms. Changes in any one isolated part of
the system will be insufficient to get the outcomes you want. The reorganization of the health system in Kyrgyzstan took about 15 years to accomplish.

Ankit Kumar from the OECD presented on Australia, which has an NHS-style system that is centrally funded, but is otherwise very decentralized. Australia has a small population spread across a large country. In order to drive physician productivity up, the government decided that they would pay physicians fee for service, which has been successful. While this comes with challenges, it is very simple to administer as you can make payments directly to the provider. In order to encourage doctors to practice in rural areas, Australia instituted mandatory training programs in rural areas for all medical students. As an incentive to practice in rural areas upon completion of their training, the government agrees to pay for medical education if upon graduating the new physician practices in a remote area. The number of years of service in a rural areas required is inversely related to how rural the service area is; so the more rural it is the fewer years of service are required. Australia is also looking at expanding the boundaries of professional nurses, and expanding the practice of nurses.

Dr. Kumar also presented how to get primary care wrong, using Korea as an example. In Korea, hospitals are driving service delivery. This is because people don’t trust the primary care system, and would rather go to the hospital where there is higher technology and higher perceived quality of care. The hospitals are largely private. Over time, as people have gotten richer, there has been a progressive loss of faith in the public sector and public clinics, and people are opting to go to the private sector instead. This model however is very expensive and creates inequality in access to care.

Dr. Somsak Chunharas gave the final remarks from the expert panel. He presented some lessons from the case studies and presentations at the convening, and also shared warnings base in his own experience in Thailand.

Dr. Somsak advised countries to start wherever you are with gradual efforts to increase coverage, both in terms of population and service items. He advised that countries define realistic desirable system outcomes with macro system design mechanisms. There should be systems research and learning mechanisms as well as capacity to guide the evolution of the system based on a changing environment, performance, and available resources.

Mr. Somsak presented several key issues that were discussed during the convening:

- **The roles and inclusion/involvement of doctors** – it is important to define what doctors are expected to do with regard to prevention, promotion, environmental health etc.

- **Influencing medical professionals** is necessary so that they are supportive rather than resistant to PHC concepts and values
• **Addressing non-professional career ladders** – in order to retain lower level staff, it is crucial to consider how they should be moved up professionally to keep them satisfied and productive without necessarily entering into the professional career dimension

• **Institutionalizing learning** - Having an adapting health system requires making continual learning an integral part of system operations and day-to-day work

• **Ensuring quality and accountability of services** – it is challenging to maintain quality given the "task shifting" approaches and spreading limited resources over a wide area of coverage. Having monitoring systems in place (for example, the national audit in Brazil) will hold people at all levels accountable

• **Creating a long-term vision and sustainability plan** for a health system based on PHC ideals will keep the system focused on prevention and equitable care and prevent it from falling into traps of specialization

In closing, Mr. Somsak made several recommendations pertinent to Ethiopia based in his personal experience and lessons from the convening discussions:

• **Leadership is crucial** in setting up a workable system (as long as the leaders are guided by the right thinking). Not only will leadership decide whether to finance PHC but will also have the command and trust of donors, the influence to design a workable system, and the ability to inspire workers and people.

• **Aim high** - though you will have to be "selective" under the reality of resource constraints, you should aim high

• **Lay out workable facilities in the periphery** to carry out "defined functions" with both curative and preventive services, and equip and staff these facilities to do as many things as possible (don't be over-selective). People have less trust in facilities and staff that cannot "handle" their problems. Emergency and curative needs are two good examples of worthwhile services to invest in at peripheral facilities.

• **Set up a good supervision system** and relationships with higher levels of care so that they can be as responsive as possible rather than addressing priority health needs determined only by experts/statistics.

• **Flexible HRH is key** – Remember that what medical professionals and non-professionals know and can do is different from what they are paid for or supported to do. People, training, money and performance interact differently if each element is not too strictly matched.
• **Attitudes and values are crucial** - both of health personnel and community members, and need to be encouraged and reinforced from various levels, particularly from leaders

• **Financial Autonomy of health facilities** will allow them to innovate and be more dynamic/responsive to people's demands in their service provision

• **Use HIS as feedback to improve performance** rather than solely for higher level reporting

• **Maintain close and interactive consultation** between lower and higher levels and share and learn from opportunities and experiences within all levels

**Conclusions**

The case studies presented pose excellent learning opportunities for Ethiopia. They demonstrate diverse models of service provision, organization and management of health services, organization of financing and payment mechanisms, engagement community members, political engagement, system learning and improvement. This mutual sharing of experiences across the spectrum of social and economic development will serve Ethiopia in the strategic development of the Health Extension Platform and the overall primary care system.

There were six key messages distilled from the convening meeting:

1. **Context Matters:** In developing primary care systems, context matters tremendously in the type of system that gets developed. Important factors include the historical development of primary care organizations (clinics, community workers, hospitals, etc.); the role and influence of government administrators and medical and paramedical professionals; the political history of the governance systems; and other factors. There is no single right system; systems must be fit to their context. That said there are important lessons to be learned about how to make systems more effective and efficient even in different contexts.

2. **Coordination is Crucial:** Prof. Bradley's "buckets" and other related frameworks on health systems components, such as "control knobs" and "building blocks" lead us to some important observations. First, effective primary care systems are about more than just improving specific health indicators, such as those related to the MDGs, and indeed about more than just health. Financial protection and citizen satisfaction are important outcomes for effective primary care. Second, most if not all health systems domains need to be developed in a coordinated way to create effective primary care. Just providing inputs such as staff, building, and supplies; or just implementing financial incentive schemes or new management and information systems is unlikely to be sufficient to create an effective primary care system. A coordinated approach involving multiple domains is needed.
3. **Vision Must Meet Feasibility**: The WHO report "Primary health care" in both its 1978 and its 2008 version provides an inspiring vision. But countries at different stages of economic and health system capacity must adapt that vision to a feasible strategy of achievable outcomes and health system development. Primary care system development strategies must combine ambitious vision and rigorous practicality.

4. **Understand and Engage “The Community”**: Engaging citizens, beneficiaries, and the community have been shown to be key elements of developing successful primary care. This should include, at least, attention to the demand-related aspects of access and use of priority services, as well as potential community roles as both providers and monitors/regulators. While thinking of community engagement, we should try to avoid an overly "rose-colored" view of what "the community" is – it is important to keep in mind that in many countries social disparities and other intra-community divisions are important issues that can also impede the development of effective primary care systems.

5. **Generate Further Learning from Case Studies along the Development Continuum**: This convening meeting illustrated the value of more in-depth case studies. Even successful systems can be quite different in their design and operation. Countries designing or adapting their primary care system would benefit from documentation of the development and evolution of primary care systems along the path the economic and social development. These have been relatively rare, so that our evidence base is often "pre" and "post" but little about what happened in between.

6. **Define Characteristics of Primary Care Systems**: More work is needed to develop systematic definitions and measures of the "characteristics" of primary care system processes. Recent work by the OECD is an important advance in this area. We need to take this forward more in lower and middle-income countries. The objectives of more case studies and unpacking of primary care characteristics should not be to identify one preferred model, but rather to understand better the lessons of different experiences. Meetings such as this convening could form the seeds for a future network of research and policy development on the development of primary care systems.

The Harvard and Yale teams will continue to work with the Ethiopian delegation to facilitate the development of a vision and strategic implementation plan for the HEP over the next few months and beyond, utilizing lessons learned from this important convening.