In a globalizing world, PHC policy reviews can take advantage of the emerging within- and across-country collaborative networks to build up the critical mass that can lead and implement the necessary reforms. Indeed, for many countries, it is not realistic to find, within their own institutions, all the technical expertise, contextual knowledge and necessary capacity for dispassionate analysis that PHC policy reviews require. Open, inclusive and collaborative structures, such as the Latin American observatory models[23], can go a long way in harnessing the diversity of national resources. Such models also make it possible to derive further benefits from international collaboration and to overcome the scarcities within a single nation's capacities. Policy-makers today are more open to lessons from abroad than they may have been in the past, and are using them to feed national policy dialogue with innovative approaches and better evidence of what works and what does not[22]. Embedding national institutions in regional networks that collaborate around PHC policy reviews makes it possible to pool technical competencies as well as information. Importantly, it can create regional mechanisms to get more effective representation in important but labour-intensive global bodies, with less strain on scarce national resources.

More structured and intensive inter-country collaboration around PHC policy reviews would yield better international comparative data on variations in the development of health systems based on PHC, on models of good practice and on the determinants of successful PHC reforms. Such information is currently often either absent, hard to compare or outdated. By building on networks of experts and institutions from different regions, it is possible to produce consensus-based and validated benchmarks for assessing progress and easier access to (inter)national sources of information relevant to monitoring primary care. This could make a big difference in steering PHC reforms. Various initiatives in this direction, such as the Primary Health Care Activity Monitor for Europe (PHAMEU)[24], a network of institutes and organizations from 10 European Union Member States, or the Regional Network on Equity in Health (EQUINET)[25], a network of professionals, civil society members, policy-makers, and state officials in Southern Africa, are promising steps in that direction.

There is a huge research agenda with enormous potential to accelerate PHC reforms that requires more concerted attention (see Box 6.3). Yet, currently, the share of health expenses devoted to determining what works best – to health services research – is less that 0.1% of health expenditure in the United States, the country that spends the highest proportion (5.6%) of

Box 6.3. From product development to field implementation – research makes the link[27]

The WHO-based Special Programme for Research and Training in Tropical Diseases (TDR) has been a pioneer in research to inform policy and practice. TDR-sponsored studies were the first to broadly document the efficacy of insecticide-treated bednets for malaria prevention in the mid-1990s, in multi-country, multi-centre controlled trials. Following introduction of the drug Ivermectin for onchocerciasis, or "river blindness", control in the late 1980s, TDR, together with the African Programme for Onchocerciasis Control, initiated research on how best to get Ivermectin into mass distribution in the field. What evolved was a tested and fine-tuned region-wide system for "community-directed treatment" of river blindness, described as "one of the most triumphant public health campaigns ever waged in the developing world."[28]

Now, as the global health community moves away from vertical disease control, operational research is facilitating the shift. Recent TDR-supported large-scale, controlled studies involving 2.5 million people in 35 health districts in three countries have demonstrated that the community-directed treatment methods developed to combat river blindness can be utilized as a platform for integrated delivery of multiple primary health-care interventions, including, bednets, malaria treatment and other basic health-care interventions, with significant increases in coverage. For example, more than twice as many children with fever received appropriate antimalarial treatment, exceeding 60% coverage on average. Critical to both the funding and execution of such research are the partnerships fostered with countries in the region, as well as other public, civil society and private institutions. The vision now is to make implementation and operations research an even more important element of global research agendas, so that new products may finally begin to yield their hoped-for health impact through sounder primary health-care system implementation. Thus, the long-standing burden of deadly diseases, such as malaria, may be more effectively addressed – through global, regional and local knowledge-sharing and cooperation.

its health expenditure on biomedical research[26]. As another striking example, only US$ 2 million out of US$ 390 million in 32 GAVI Health System Strengthening grants were allocated to research, despite encouragement to countries to do so. No other I$ 5 trillion economic sector would be happy with so little investment in research related to its core agenda: the reduction of health inequalities; the organization of people-centred care; and the development of better, more effective public policies. No other industry of that size would be satisfied with so little investment in a better understanding of what their clients expect and how they perceive performance. No other industry of that size would pay so little attention to intelligence on the political context in which it operates – the positions and strategies of key stakeholders and partners. It is time for health leaders to understand the value of investment in this area.

Mobilizing the commitment of the workforce

Each of the sets of PHC reforms emphasizes the premium placed on human resources in health. The expected skills and competencies constitute an ambitious workforce programme that requires a rethink and review of existing pedagogic approaches. The science of health equity and primary care has yet to find its central place in schools of public health. Pre-service education for the health professions is already beginning to build in shared curricular activities that emphasize problem-solving in multi-disciplinary teams, but they need to go further in preparing for the skills and attitudes that PHC requires. This includes creating opportunities for on-the-job learning across sectors through mentoring, coaching and continuing education. These and other changes to the wide array of curricula and on-the-job learning require a deliberate effort to mobilize the responsible institutional actors both within and across countries.

However, as we have learned in recent years, the content of what is learned or taught, although extremely important, is but one part of a complex of systems that governs the performance of the health workforce[1]. A set of systems issues related to the health workforce need to be guided to a greater degree by PHC reforms. For example, health equity targets for underserved population groups will remain elusive if they do not consider how health workers can be effectively recruited and retained to work among them. Likewise, grand visions of care coordinated around the person or patient are unlikely to be translated into practice if credible career options for working in primary-care teams are not put in place. Similarly, incentives are critical complements in ensuring that individuals and institutions exercise their competencies when engaging health in all policies.

The health workforce is critical to PHC reforms. Significant investment is needed to empower health staff – from nurses to policy-makers – with the wherewithal to learn, adapt, be team players, and to combine biomedical and social perspectives, equity sensitivity and patient centredness. Without investing in their mobilization, they can be an enormous source of resistance to change, anchored to past models that are convenient, reassuring, profitable and intellectually comfortable. If, however, they can be made to see and experience that primary health care produces stimulating and gratifying work, which is socially and economically rewarding, health workers may not only come on board but also become a militant vanguard. Here again, taking advantage of the opportunities afforded by the exchange and sharing of experience offered by a globalizing world can speed up the necessary transformations.

Mobilizing the participation of people

The history of the politics of PHC reforms in the countries that have made major strides is largely unwritten. It is clear, however, that where these reforms have been successful, the endorsement of PHC by the health sector and by the political world has invariably followed on rising demand and pressure expressed by civil society. There are many examples of such demand. In Thailand, the initial efforts to mobilize civil society and politicians around an agenda of universal coverage came from within the Ministry of Health[29,30]. However, it was only when Thai reformers joined a surge in civil society pressure to improve access to care, did it become possible to take advantage

of a political opportunity and launch the reform[31]. In just a few years, coverage was extended and most of the population was covered with a publicly funded primary-care system that benefit-incidence analysis shows to be pro-poor[32,33]. In Mali, the revitalization of PHC in the 1990s started with an alliance between part of the Ministry of Health and part of the donor community, which made it possible to overcome initial resistance and scepticism[34]. However, sustained extension of coverage only came about when hundreds of local "community health associations" federated in a powerful pressure group to spur the Ministry of Health and sustain political commitment[35]. In western Europe, consumer organizations have a prominent place in the discussions on health care and public policies relating to health, as have many other civil society organizations. Elsewhere, such as in Chile, the initiative has come from the political arena as part of an agenda of democratization. In India, the National Rural Health Mission came about as a result of strong pressure from civil society and the political world, while, in Bangladesh, much of the pressure for PHC comes from quasi-public NGOs[36].

There is an important lesson there: powerful allies for PHC reform are to be found within civil society. They can make the difference between a well-intentioned but short-lived attempt, and successful and sustained reform; and between a purely technical initiative, and one that is endorsed by the political world and enjoys social consensus. This is not to say that public policy should be purely demand-driven. Health authorities have to ensure that popular expectations and demand are balanced with need, technical priorities and anticipated future challenges. Health authorities committed to PHC will have to harness the dynamics of civil society pressure for change in a policy debate that is supported with evidence and information, and informed by exchange of experience with others, within and across national boundaries.

Today, it is possible to make a stronger case for health than in previous times. This is not only because of intrinsic values, such as health equity, or for the sector's contribution to economic growth – however valid they may be, these arguments are not always the most effective – but on political grounds. Health constitutes an economic sector of growing importance in itself and a feature of development and social cohesion. Reliable protection against health threats and equitable access to quality health care when needed are among the most central demands people make on their governments in advancing societies. Health has become a tangible measure of how well societies are developing and, thus, how well governments are performing their role. This constitutes a reservoir of potential strength for the sector, and is a basis for obtaining a level of commitment from society and political leadership that is commensurate with the challenges.

Economic development and the rise of a knowledge society make it likely, though not inevitable, that expectations regarding health and health systems will continue to rise – some realistic, some not, some self-serving, others balanced with concern for what is good for society at large. The increasing weight of some of the key values underlying these expectations – equity, solidarity, the centrality of people and their wish to have a say in what affects them and their health – is a long-term trend. Health systems do not naturally gravitate towards these values, hence the need for each country to make a deliberate choice when deciding the future of their health systems. It is possible not to choose PHC. In the long run, however, that option carries a huge penalty: in forfeited health benefits, impoverishing costs, in loss of trust in the health system as a whole and, ultimately, in loss of political legitimacy. Countries need to demonstrate their ability to transform their health systems in line with changing challenges as well as to rising popular expectations. That is why we need to mobilize for PHC, now more than ever.

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Index

D

E

F

G

H

I

O

P

U

V

W

Z