Prince Mahidol Award Conference

Report on the Prince Mahidol Award Conference 2008

31 January - 1 February 2008
Bangkok, Thailand

Three Decades of Primary Health Care: Reviewing the Past and Defining the Future

Report on the

Prince Mahidol Award Conference 2008

Three Decades of Primary Health Care:
Reviewing the Past and Defining the Future

A Most Distinguished Scholar and Scientist is Conferred the Prince Mahidol Award for 2008

Sanduk Ruit
Medical Director, Tilganga Eye Centre, Nepal
Prince Mahidol Awardee 2007

Sanduk Ruit was born in a mountain area of Nepal so remote that the nearest school was eleven days away, by foot. Diligence brought him a scholarship to be educated in India. When he was seventeen, his older sister died of tuberculosis and this painful loss led him to medicine. Upon completing medical school in India, he returned to Nepal as a government health officer. Following an assignment with the WHO Nepal Blindness Survey in 1980, he completed a residency in ophthalmology. Later, in Australia, he learned from his friend and mentor Dr. Fred Hollows the latest techniques in cataract microsurgery using implanted intraocular lenses.

In the late 80's, Dr. Ruit and his team first simplified the cataract surgical technique and made it appropriate for local conditions. They struggled hard to develop an efficient, simple, cost effective and high quality cataract surgery delivery system in Nepal.

Dr. Ruit and his colleagues have over the last 20 years been spreading this technology to many parts of the world, particularly in Asia. This system has been received extremely well by hundreds of thousands of patients, eye doctors, health personnel and politicians in many parts of Asia.

Over a period of time, this technique and system has been evolved together with the evolution of technology in the western world. The most important for this is that his group has always attempted to provide the best outcome of surgery even to the most under privileged and into the most remote areas of the world, and, to be made affordable to them. Also, this technique of modern cataract surgery and philosophy has been passed onto more than five hundred eye surgeons from around the world and they are now applying it for the benefit of patients in their own areas.

The cost of an intra ocular lens used for this modern cataract surgery was very high - about US$100 per lens. Dr. Ruit took the initiative, with the Fred Hollows Foundation, to manufacture these lenses locally for about $4. This has been a tremendous breakthrough in the process of providing high quality and modern technology to the masses. Until now, the Fred Hollows Foundation has provided about 3.5 million high quality intraocular lenses.

The Tilganga Eye Centre acts as a model for instituting the concept of high quality eye care for the community and for developing an effective cost recovery scheme. This efficient model of eye care has been quoted by many and is now practiced in many parts of the world. Dr. Ruit was one of the founders of Tilganga Eye Centre, which opened in 1994.

Dr. Ruit is a co-founder and a Director of the Himalayan Cataract Project. With the Fred Hollows Foundation, Tilganga Eye Centre is working very closely in developing different systems and surgical techniques. Tilganga Eye Centre, in close conjunction with its partners, is spreading this very effective and proudly Nepalese system, in many parts of Africa, South America, Thailand, Bhutan, Myanmar, Cambodia, China, Pacific Islands, Bangladesh, India, Pakistan, etc.

Messages from the Chairs of the Organizing Committee

Prof. Dr. Vicham Panich
Chair
Organizing Committee
International Award Committee,
PMAF, Thailand

Dr. Ian Smith
Co-Chair
Organizing Committee
Advisor to the Director- General,
WHO, Switzerland

Dr. Toomas Palu
Co-Chair
Organizing Committee
Lead Health Specialist,
World Bank, Cambodia

The year 2008 marks the 30th year of the Alma Ata Declaration (1978) on Primary Health Care (PHC) to achieve Health for All by 2000, and a mid-point to the commitment to reach the 2015 Millennium Development Goals. Over the three decades that followed the Declaration, there have been many significant achievements, especially in the reduction of infant and child deaths, improvement in immunization coverage and increased access to clean water and sanitation. Nevertheless, an unaccomplished agenda remains. The main concerns are to minimize health inequities between the rich and the poor, to revitalize the functioning of PHC in the changing context of globalization and to meet the complexity of health challenges, now and in the future.

In this connection, “Three Decades of Primary Health Care: Reviewing the Past and Defining the Future” was chosen as the theme for the Prince Mahidol Award Conference in 2008. We hope that the Conference has served as a neutral and participatory Global Forum to discuss significant global health issues and provide recommendations for further actions.

This Conference is the third in the series of PHC conferences (Buenos Aires August 2007, Beijing November 2007, Bangkok January-February 2008 and others scheduled in Africa and Kazakhstan in 2008) to commemorate the 30th anniversary of PHC.

As Chairs of the Organizing Committee, we are grateful to all contributions provided by the many organizations that made the Conference a success. Main contributors were the World Health Organization, the World Bank, the Prince Mahidol Award Foundation, and the Royal Thai Government who co-hosted this conference. Each parallel session was sponsored by organizations that provided support in terms of technical assistance and/or funding support to the participants. We are most thankful to the following organizations: China Medical Board, Global Fund to fight AIDS, Tuberculosis and Malaria, Global Alliance on Vaccines and Immunization, Global Health and Security Initiative-NTI, Global Health Workforce Alliance, Google Foundation, Health Metrics Network, Mekong Basin Disease Surveillance Network, the French Embassy in Thailand, the Rockefeller Foundation, and UNAIDS. Finally, we would like to express our appreciation to the Secretariat Team who worked so hard in preparing for the Conference.

Prince Mahidol Award

The Prince Mahidol Award was established in 1992, to commemorate the 100th birthday anniversary of Prince of Mahidol of Songkla who is recognized by the Thais as 'The Father of Modern Medicine and Public Health of Thailand'.

His Royal Highness Prince Mahidol of Songkla was born on January 1, 1892, a royal son of Their Majesties King Rama V and Queen Savang Vadhana of Siam. He received his education in England and Germany and earned a commission as a lieutenant in the Imperial German Navy in 1912. In that same year, His Majesty King Rama VI also commissioned him as a lieutenant in the Royal Thai Navy.

Prince Mahidol of Songkla had noted, while serving in the Royal Thai Navy, the serious need for improvement in the standards of medical practitioners and public health in Thailand. In undertaking such mission, he decided to study public health at M.I.T. and medicine at Harvard University, U.S.A. Prince Mahidol set in motion a whole range of activities in accordance with his conviction that human resources development at the national level was of utmost importance and his belief that improvement of public health constituted an essential factor in national development. During the first period of his residence at Harvard, Prince Mahidol negotiated and concluded, on behalf of the Royal Thai Government, an agreement with the Rockefeller Foundation on assistance for medical and nursing education in Thailand. One of his primary tasks was to lay a solid foundation for teaching basic sciences which Prince Mahidol pursued through all necessary measures. These included the provision of a considerable sum of his own money as scholarships for talented students to study abroad.

After he returned home with his well-earned M.D. and C.P.H. in 1928, Prince Mahidol taught preventive and social medicine to final year medical students at Siriraj Medical School. He also worked as a resident doctor at McCormick Hospital in Chiang Mai and performed

operations alongside Dr. E.C. Cord, Director of the hospital. As ever, Prince Mahidol did much more than was required in attending his patients, taking care of needy patients at all hours of the day and night, and even, according to records, donating his own blood for them.

Prince Mahidol's initiatives and efforts produced a most remarkable and lasting impact on the advancement of modern medicine and public health in Thailand such that he was subsequently honoured with the title of "Father of Modern Medicine and Public Health in Thailand".

In commemoration of the Centenary of the Birthday of His Royal Highness Prince Mahidol of Songkla on January 1, 1992, the Prince Mahidol Award Foundation was established under the Royal Patronage of His Majesty King Bhumibol Adulyadej to bestow international awards upon individuals or institutions which have made outstanding and exemplary contributions to the advancement of medical, and public health and human services in the world.

The Prince Mahidol Award will be conferred on an annual basis with prizes worth a total of approximately USD 100,000. A Committee, consisting of world-renowned scientists and public health experts, will recommend selection of awardees whose nominations should be submitted to the Secretary-General of the Foundation before May 31st of each year. The committee will also decide on the number of prizes to be awarded annually, which shall not exceed two in any one year. The prizes will be given to outstanding performance and/or research in the field of medicine for the benefit of mankind and for outstanding contribution in the field of health for the sake of the well-being of the people. These two categories were established in commemoration of His Royal Highness Mahidol's graduation with Doctor of Medicine (Cum Laude) and Certificate of Public Health and in respect to his speech that:

"True success is not in the learning, but in its application to the benefit of mankind".

The Prince Mahidol Award ceremony will be held in Bangkok in January each year and presided over by His Majesty the King of Thailand.

Thirty Years of PHC: Discerning the Past, Understanding the Present and the Way Forward



Keynote speakers
Dr. Anarfi Asamoa-Baah, Dr. Joy Phumaphi and Dr. Sanduk Ruit

PHC is fundamental and has a great impact to society. No one can do this alone - partnership is important, and commitment of leadership is the key. Investing in human resources is critical. Surveillance and response needs to build on existing capacities and resources. Preparedness is essential and should be built on the rapidly changing world and the momentum of disease specific threats.

Past experiences have shown the achievements in some countries such as Thailandís successful campaign against the HIV/AIDS epidemic and the control of SARS spreading. The key factor lies in the vision, foresight and leadership of HRH the Princess and the King. The world is changing rapidly and PHC has faced many challenges. The theme **"**future directions of PHC**"** is proposed.

The main obstacles and mistakes learned from past experience are as follows:

1. Financing - Unexpected/unprepared world-wide economic crises are increasing and leading to severely limited resources.

2. Lack of community participation - Failure to maximize the energies and ambitions of locals, civil officers, NGOs and the private sector.

3. High expectation from people for better health care and quick results with various choices.

4. Shortage of human resources - especially trained and motivated health workers.

5. Emergence/re-emergence of infectious/preventable diseases and increased pace of spread - serious and unusual disease events are increasing and inevitable. A selective and fragmented PHC approach has become inadequate. For example, the AA list of eight essential elements of PHC gave a shopping list from which to select a few elements that might bring quick results.

6. Health industry - Business/profit-oriented industry. Corruption occurs at many levels of health sectors, which also do not have skill/ tools or clout to persuade other sectors.

7. Globalization - Growing world population has increased consumption of food, drugs and fundamental resources. People are moving more than ever, seeking greener pastures for survival, wealth or tourism, and giving us greater connectivity. The more interconnected world leads to the rapid spread of epidemic and pandemic diseases. Universalizing of certain food tastes is leading to greater breeding and slaughter of food animals leading to greater danger from diseases of animal organs. Public health events in one location/region may be a threat to others.

8. Mental health problems, stress, and dysfunctional families are all on the increase. PHC should address these and other non-communicable diseases.

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

Suggested Solutions for Understanding the Present and the Way Forward

PHC must be put at the top priority and we must take advantage of this new high status as a contributor to poverty reduction and economic gain. Health is being seen as a foundation for prosperity and social stability. These assets give health care more political clout. The PHC

of the future should aim to address all the challenges including finance, human resources, public awareness, globalization, threat of communicable and non-communicable diseases, business-oriented health systems and even natural disasters. Health systems need to be strengthened across the board and should focus on verifiable results with better cooperation and multiple integrations.

1. At the local level - Detection of events, reporting and control measures. Implement the PHC in such a way that there is community ownership and there remains financial autonomy. Modify complex and expensive procedures/equipment into simple and affordable technologies while maintaining good quality, even as they are adapted to local circumstances e.g. low-priced lens for cataract patients.

2. At the national level - Countries need to pay more attention to budget management and to strengthen national disease surveillance, prevention, control, and integrated health care systems. The advantages of better information technology (internet) and improved medical technologies should be combined to lower the cost and complexity of health care given.

3. At the international level - Foster global partnerships. WHO, all countries and all relevant sectors are made aware and collaborate to provide the best available support and, where needed, mobilize the necessary resources. Bringing together and applying various disease specific strategies to support core capacity building. Move more effectively from principles to national capacity and supranational solidarity necessary for implementation.

4. Global organizations and high income countries - Provide technical and financial support to low and lower middle income countries and give support to human resource training and networks, and developing quality health care systems. The new approach is focused on verifiable results. Health needs money and innovative funding is necessary and growing, as is the size of resources it commands, such that the proliferation of partners needs to be monitored so as not to cause chaos in countries.

Stakeholders should involve all levels of the society, including individuals, family members, local communities, government, NGOs, charity foundations, private sector, insurance agencies and UN agencies.

Panel session
Primary Health Care: Past Achievement, Future Challenges and Responses: Five Country Case Studies

The panel session on five country case studies set the scene on the global experiences on Primary Health Care (PHC) in the last three decades, and described the need for PHC to redefine its mandates to fit the unfinished and new challenges. In a changing context of increasing numbers of international health partners and significant increases in donor resources for health, unfinished agendas remain, notably in relation to global commitments by all governments and international development partners on achieving MDG4 (child mortality) and MDG5 (maternal mortality). It is evident that a large number of countries will not meet their Millennium Development Goals by 2015 at the current rate of progress.

Several major observations were made: relative under-spending on MDG4 and MDG5 compared with HIV/AIDS. PHC in poorer countries is not functioning, though there are some innovative supply and demand side interventions that warrant scaling up.

In addition, low levels of total health expenditure per capita and the dominant role of household out-of-pocket expenditure has resulted in catastrophic outcomes and impoverishment for people in many countries. Reliance on donor funding and technical inputs in poorer countries pose problems for financial and programmatic sustainability. Adequate human resources, skill-mix, staff-mix, morale and retention are major bottlenecks of a functioning PHC to achieve MDG, especially in the light of emerging infectious diseases threats and an increasing proportion of chronic non-communicable diseases.

International evidence exists on low cost but effective public health interventions and treatment, but translating these into effective programmatic implementations, and well resourced functioning PHC remains a major challenge.

Six thematic parallel sessions boosted in-depth deliberations by speakers, panelists and participants. Two main drivers for a functioning PHC: human and financial resources were discussed in the global context which has major impetus on PHC; globalization, intellectual property and liberalization of trade in health services, and global health initiatives such as the Global Fund, GAVI and PEPFAR. Two other in-depth deliberations related to the evidence-base for decision making - firstly the role of PHC in public health function notably disease surveillance to guide better communicable and non-communicable diseases control, and secondly, a revisit of health information systems.

These six inter-related mechanics of PHC described above must operate under a "human face" through empowering the community, family and households, boosting ownership through a participatory processes, and effective intersectoral collaborations. An analogy to revitalizing PHC is weaving a "social fabric". It requires both vertical and horizontal threads.

The Conference reaffirmed that the equity and universal principle of PHC are still valid, though PHC functions need to be redefined based on country specific contexts of socio-economic and health systems developments. The unfinished agenda of a functioning PHC is a result of financial and human resource constraints. Three balances were proposed: balance in spending across MDG targets, balance in vertical and horizontal programs through better integration of PHC, and balance between the mechanics and the "human face". Finally, it is the

governments, international development partners and other stake holders' responsibilities to revitalize PHC in a changing global context.

It is hoped that the deliberations of the Conference will be useful as input for further global consultations on PHC in 2008.

The Conference acknowledges contributions by all partners, including co-host agencies of the Conference, co-sponsors of sessions, chairs and co-chairs of sessions, speakers, panelists, participants, rapporteurs and the Secretariat.

"Primary health care is about social change. Social changes do not come about on their own, they need a movement and committed leadership." ... Asamoa-Baah, Deputy Director-General, WHO

"**What can we do...to achieve the MDGs. We need to strengthen health systems across the board; we need to focus on verifiable results; we all need to work together better."** .... Joy Phumaphi, Vice President HDN, World Bank

Who Services Primary Health Care and How Can They be Effectively and Equitably Created, Motivated and Maintained to Provide Good PHC Services?

Long before the Alma Ata Declaration in 1978, many developing countries had experienced some informal form of community health workforce. Parents and family members have always been first level practitioners, and there was availability of 'social capital' in the rural communities such as traditional healers, spiritual healers, and informal providers who provided care where there was no health professional. Riding on the wave of the Alma Ata Declaration, the primary care approach in many developing countries has been integrated into the main stream health services, but not always successfully.

Five themes emerged from the Alma Ata Declaration: the importance of equity, the critical role of community participation, the emphasis on health promotion, multisectoral approach to health problems, and the need to adapt appropriate technology to improve health. These have shaped the need for appropriate health workforce. Three main groups of health workforce working inter-relatedly have played important roles to service primary care. The first group is highly qualified health professionals whose services are mainly curative. The second group is community health workers, locally trained to provide front-line health services to rural communities. The third group is community members themselves, comprising a variety of forms of volunteers, family members, etc. who provide mainly preventive care at communities. It is important to maintain and motivate this workforce in rural areas. For health professionals, a range of motivations such as salary, career

path, good working condition, etc. play an important role in retaining them. In the case of community health workers, social recognition is found to be a significant retention factor, and that of community volunteers should emphasize ownership.

However, many developing countries have encountered the situation of shortages of highly qualified health workers, inaccessibility to care, and limited resources. Task-shifting is considered an appropriate approach to fill these gaps. Specific tasks are delegated, from highly qualified health workers to community health workers, and from community health workers to community volunteers in order to make more efficient use of the available health workforce and to provide services to people that are accessible, high quality, cost-effective, and acceptable to the clients.

Recommendations for creating effective and equitable, motivated and maintained PHC services?

1. Build up partnerships for health and involve all concerned stakeholders: public, private, communities, civil society, and local authorities, to communicate and plan for the effective health care systems as well as find solutions for the health workforce.

2. System design must be context specific and culturally, politically, and economically appropriate. Community health workers must be rooted in the community and can serve a transformative role.

3. Reorientation of health professionals' attitudes towards primary health care and broaden the scope of the health workforce to cover volunteers, traditional healers, and care takers at community level.

4. Integrate community services into the main stream health system and recognize the roles of community volunteers as well as provide technical support: training, supervision, and equipment to community volunteers.

5. Clear definition of roles, supervisory structures, referral patterns, and incentive packages for health workers at all levels. Pure volunteerism is not sustainable in many situations.

6. Consider implementing task-shifting related to the country context, but key issues need to be in place: standardization of tasks, initial training and technical support. Properly implemented task-shifting can be done without adverse and even with positive impact on quality, cost, patient outcomes, and patient satisfaction.

7. A range of appropriate motivations to retain health professional in rural settings should be in place, and measures to motivate community health workers as well as community volunteers should be considered.

PHC and Public Health Surveillance and Response

This session of PMAC addressed surveillance-related activities and roles at the local, national and global levels. These are not independent, but rather, interdependent: they have probably always been interdependent but are even more so in the current context of globalization. Speakers referred to this as **"bottom-up meets top-down"** and **"head-shoulders-knees-toes"**. The first set of presentations addressed a new global framework (the revised IHR (2005)) and local level surveillance for two global disease eradication programs (polio and dracunculiasis or Guinea Worm disease). The second set of presentations focused on new technologies for surveillance and the emergence of regional surveillance networks. Much has been learnt from past experiences and building upon surveillance infrastructures beyond their original purpose (which may help address the problem of sustainability).

Presentations and the ensuing discussions signal that we are ***advancing socially:*** The following points outline our advances in health surveillance and response:

- Adding the **"**heart**"** component to our efforts, which also enhances sustainability (beyond purely financial resources)
- Better engaging communities: the power and empowerment of the people, which has developed significant human capital - a huge return on investment that should not be lost
- Engaging multiple sectors
- Countries organizing themselves into regional and sub-regional surveillance networks - complementary to WHO/IHR, based on mutual trust, and driving data to information for action. There is now a desire to coalesce these into a global network of networks

The presentations and discussions also indicated that we are ***advancing technologically*** and applying new technologies, e.g. related to aboratory, information and communications technologies (ICT), and Geographical Information Systems (GIS). These are based on a new paradigm in which we must assume that new technologies can reach the grassroots level, rather than the old paradigm that seemed to suggest that they cannot.

It is clear that political commitment at the highest levels is critical and that capacity building for all elements of surveillance is important to countries and consistent with IHR(2005): human resources, laboratory, and information systems. Scaling up is another key priority, but capacity at the local level must become sustainable, and this is challenging. Multi-sector engagement is critical, e.g. Ministries of Health, Agriculture, Foreign Affairs and Education. Global policies reach the local level, and local level actions must have global impact.

Three key lessons on PHC and Public Health Surveillance and Response

- We must have the wisdom to maintain the best of what we have created and learned, while also having the courage to embrace new paradigms ("heart", "top-down meets bottom-up", new social norms and technologies)
- Everyone is a stakeholder: WHO, countries, external partners, private sector, local populations
- Let us act on the lessons we have learned, so that we do not have to repeatedly learn those same lessons again, but rather, can advance surveillance to reduce disease burden and improve lives.

Impact of Global Health Initiatives (GHI) on PHC and their Contribution to Strengthening Health Systems

GHIs have brought new resources, some of them additional, to the health sector. There is also some evidence, mainly anecdotal, that GHIs have contributed to building capacity in the health system. However, there is also other evidence that GHIs have weakened aspects of the health system, and reduced the capacity of countries to meet their prioritized needs. A key issue is how the positive contributions of GHIs can be maximized while minimizing the negative impacts.

GHIs typically operate independently, both of the existing health system and of other GHIs. There is a need for greater harmonization of GHI and other stakeholders at the global and at the country level. To what extent will GHI accept partnership?

GHIs may have led to too much of a focus on technology as the solution to solving health problems to the detriment of dealing with the social and environment determinants of health outcomes. All actors, including GHI need to work to support country development and ownership of one country health plan for each country. GHIs need to support these country health plans and align their resources to country needs. How this can be accomplished is an issue for discussion.

The evidence base for the impacts of GHIs on supporting or harming the development heath systems need is weak and needs to be strengthened. We must balance the need to address urgent health problems with the long-term need to develop the capacity of health systems. It is easier to demonstrate performance through disease

of issue-specific programs. Results-based performance has supported the development of vertical programs. Tools and strategies that provide greater accountability and performance-based rewards for comprehensive programs need to be developed.

Recommendations on Global Health Initiatives

1. Need to achieve a balance between system strengthening vs. diseases focused verticality, communicable vs. non-communicable diseases, public vs. non-public sectors, quality indicators of performance vs. quality indicators; short-term results vs. long term sustainability and capacity building, short term workshops vs. long-term capacity development, comprehensive vs. disease specific approaches, treating the consequence vs. solving the causes, response to urgent crisis vs. long term impact.

2. Need to build the evidence base on impacts of GHIs to determine the extent to which disease-based funding has actually strengthened the overall heath system. The evidence base also needs to be developed around strengthened HMIS systems that contribute to transparency and accountability.

3. Need to promote and support country ownership of health planning and implementation through ensuring the establishment of partnerships of all stakeholders that support government-identified priorities and implementation mechanisms. GHIs, governments, private sector and civil society need to work within one health plan that is country-led and controlled.

4. Need to place more focus on social and environmental determinants of health by placing greater attention on social and environmental determinants of health. GHI resources should be used to address not only proximate cause of disease, but also address less proximate causes.

5. Need to develop health system capacity through ensuring that GHI inputs are designed to increase sustainability and efficiency at all levels of the health systems - including financing, policy development, planning, and human resources.

International Trade, Trade Agreements and Health: Implications for PHC

This session examined the impact of trade agreements and of international trade in health services on access to primary health care and to essential medicines. A key challenge for governments is to design mutually supportive trade and health policies that can deliver optimal trade and health outcomes, including for PHC. This challenge is especially pressing in this region, with ASEAN Member States committed to accelerate the liberalization of trade in priority services sectors, including healthcare by 2010, increased competition in health tourism (i.e. foreign patients traveling to ASEAN countries such as Malaysia and Thailand to receive health care), and the rise of foreign investment into health establishments.

Indeed, we witnessed a growth of foreign-owned health care facilities catering mainly for the middle and upper income population segments and are mostly found in urban areas. This type of trade in health services occurs mainly outside the framework of existing trade agreements, but nevertheless has real consequences; it may create opportunities for public expenditure savings and access to better quality care, but also raises challenges in promoting equitable and affordable access.

From a PHC perspective, any discussion of trade and health needs to go beyond health services per se, by addressing other basic services such as the provision of water, sanitation, education and health insurance services. One key difficulty in monitoring the impact of trade in such services is the lack of international trade data, which is typical for services; improvement in systematic collection of information on trade in health is therefore crucial. Another proposal is for government to use the diagnostic tool on trade in health services

being currently developed by WHO in collaboration with WHO Member States, WTO, WIPO, World Bank, UNCTAD and others. The importance of stakeholder consultations to implement such a diagnostic and develop a national strategy has also been underlined by the panellists.

PMAC discussions on the impact of trade agreements on access to medicines focused on the use of flexibilities found in trade agreements and on patent protection provisions in bilateral trade agreements. It was presented that the provisions on intellectual property protection found in free trade agreements (FTAs) impinge upon the public health safeguards established in the WTO agreement on intellectual property, the TRIPS. The panellists suggested that the more public health-friendly stance of the United States in recent FTAs negotiations highlights the importance of the role of parliament, civil society and public opinion to achieve a more balanced trade deal as it relates to patent protection.

The discussion about access to medicines also examined how Thailand has successfully used TRIPS flexibilities to issue compulsory licences to make available generic drugs for antiretroviral therapy (ART). It was pointed out that the Thai actions on compulsory licensing are clearly authorized under international law. However, the experience shows that using TRIPS safeguards is difficult, and requires concerted support from other countries in the South, and civil society, international organisations especially the WHO and WTO. This initiative on how to use TRIPS flexibilities to increase access to essential drugs has triggered much international attention from all stakeholders. Finally, the panelists stressed the need to promote innovation that allows wide access to products, based on public health needs, especially the needs of those in developing countries.

Financing PHC: Allocating Resources for Improved Effectiveness and Equity

Health is widely recognized as a basic human right. In terms of financing of health care, there is currently an enormous mismatch between the global disease burden (borne largely by low-income countries) and global health expenditures (dominated by high-income countries).

In order to achieve the health MDGs, additional spending for health must be mobilized, since nearly all regions are significantly off-track to meet them. However, given their current growth patterns, many low-income countries are unlikely to be able to mobilize the domestic revenues needed to achieve the health MDGs. In addition to mobilizing revenues, countries need to look at how and how well they are spending their resources. Many are doing better in terms of health indicators than others for the same level of spending.

To increase spending on health, low-income countries must look at how they can expand their fiscal space for health by increasing taxation, diverting other spending to health, borrowing, or increased external assistance. Each of the preceding has disadvantages. It is difficult to increase taxation from its current 13 percent of GDP for low-income countries, spending in other sectors (such as education) also has priority, debt levels already are high, and external assistance is volatile and goes to donor, not necessarily country priorities. Thus, effort should go to how the limited funds are spent. For example, Ethiopia and Rwanda expect to be able to provide basic packages of services that will help them meet the MDGs at a cost of $14-18 per capita per year, in line with their capacities to mobilize resources. These amounts are much less than the $34 per capita estimated by the Commission on Macroeconomics and Health (CMH) for a primary health care-based minimum package. In addition, provider payment methods linked to performance could ensure that the maximum health

outcomes are achieved for the amount of spending possible. Greater donor alignment of their spending and programs with national priorities could make this spending more effective, too.

Country Lessons and Experiences in Financing PHC

- **Estonia:**

1) introduced independent, autonomous family physicians (comprehensive and holistic medicine) that are contracted for the provision of primary health care, with competitive user choice,

2) applied a mixed payment system, including risk-adjusted capitation, practice allowances, rural adjustments, selected fee-for-service, and bonuses related to performance,

3) is shifting from a general tax fund system to a social health insurance by earmarked payroll tax, and

4) developed referral and quality assurance systems.

These reforms have been evaluated in terms of outcomes concerning heart disease, asthma, diabetes, and depression with positive results in nearly all measures. However, despite these very positive results, it is to be noted that only Estonia of all of the post-Soviet states has been able to implement such a comprehensive, multi-faceted reform.

- **Afghanistan:**

1) has used donor funds (from the European Commission, USAID, and the World Bank) to contract with NGOs to provide care for the population with the Ministry of Health concentrating on the stewardship role, rather than service delivery,

2) the contracts are based on a standardized package and focus on PHC,

3) achieved good results for about $4.50 per capita per year: dramatically improved performance in all categories using a balanced

scorecard approach (evaluated independently by Johns Hopkins University and the Indian Institute of Health Research) and improved child health indicators in 2004/05 compared to 2001/02 (IMR from 165 to 129; U5MR from 257 to 191).

This kind of result relies on the government's willingness to concentrate on the stewardship role, and donor and NGO willingness to participate in contractual financing, the ability to specify and monitor contracts, and the eventual ability of government to take on the burden of financing from donors to ensure sustainability. Finally, government gains less in terms of legitimacy to its population when it relies on contracting as opposed to delivering services directly as it emerges from a crisis situation.

- **Latin America and Caribbean countries:** applied conditional cash transfer programs (CCT) that are poverty-targeted, demand-side interventions toward health and nutrition. The CCT programs involve governments providing sums of money (usually about $20 per month) to mothers in poor families when they and their children use specified health and education services (though verification of actual use is weak) to (1) increase the utilization of the services and (2) reward families with funds to alleviate their poverty. Results from evaluations of CCT programs in seven countries, including Mexico, Honduras, Nicaragua, and Colombia showed that CCT: (1) clearly is effective in increasing the use of PHC services, (2) has mixed effects on outcomes, (3) shows only some positive effects on a supply response to increased demand, and (4) had positive effects on women's status (mothers spent more on their children). However, information on the causal pathways between CCT and the results attained is unclear; hence this limits the interpretation of the findings. Finally, the evaluation results were not put into a cost-effectiveness context (comparing the cost of CCT to other means (such as un-conditioned transfers or supply subsidies) to attain the same effects.

Conclusions on PHC Financing

- The specific context might have important consequences for whether the positive country experiences could be replicated elsewhere, hence there is need for evaluation of the role of context-specific factors in success
- Ownership of providers might matter, especially when institutions are weak-it should be noted that the positive experiences with contracting involve NGOs, not commercial providers
- Contracting might be much easier for PHC than for other health services, such as hospitals where specifying outputs and targets would be more difficult
- The capacity to implement cash transfer programs (CCT) programs might be more limited in other countries and regions than in Latin America and the Caribbean
- History matters in terms of how PHC can be pursued in a country; Estonia and Afghanistan have been able to start from a PHC base, but Thailand invested in hospitals before PHC to respond to doctors' wishes, so now it is hard to divert consumers back to PHC from a reliance on hospitals for primary care
- PHC has underachieved as a strategy to achieve better health in many countries because insufficient attention has been given to (1) supply side incentives to providers, for example to enter family medicine, provide specific items of care, to refer appropriately, and to be responsive to consumers and (2) demand issues such as including PHC in pooled payment systems, penalty payments for bypassing PHC, and adapting CCT programs to focus on health (the ones presented were anti-poverty focused).

What should be done next in PHC Financing?

- Countries with insufficient resources to finance PHC should:
  - Try to increase the fiscal space for health but also
  - Define and finance lower cost packages of services that can be sustainably supported with domestic resources and limited external support
  - Address allocative and technical inefficiencies to increase the results obtained from available resources
- Adapt to specific contexts and where appropriate apply the lessons from countries that have had successes in PHC financing, including comprehensive reforms of financing, ownership, and content of services, contracting, and CCTs
- Give greater attention to both supply- and demand-side incentives to allow PHC to achieve more of its potential
- Continue to build the evidence base concerning financing for PHC by doing more analyses such as those presented at PMAC with more emphasis on qualitative and context-specific aspects of experiences.

Evidence, Information for Health Systems Strengthening in Support of PHC

Health information systems able to deliver sound statistics about health outcomes, determinants, and service delivery and use, are critical for the success of primary health care approaches. Investment in capacities for data generation, analysis and presentation should be a core element of strategies to build human resources.

Health information systems can be strengthened even in difficult circumstances when there is high level political commitment, strong country champions for reform, involvement at all levels of the health care system, community participation, and coordinated support from donors and development agencies.

It is important to build stronger links between producers and users of health information. It is not enough to collect and summarize data; further analysis is required before the information can be disseminated and communicated and used as the basis for making policy. Presentation of complex information in simple charts and maps is a well-tested route to enhancing the use of data for decision making.

Unparalleled opportunities for improving the availability and communication of health information are offered by new technologies for data capture, exchange and presentation. Hand held devices for data capture and global positioning systems are now available at low cost and can be used by local health managers and communities to gain a better understanding of local health risks, availability and use of services.

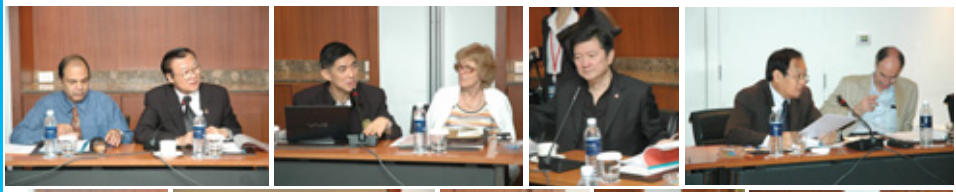
The electronic medical record (EMR) is increasingly a critical source of clinical information and can be particularly important for primary

care delivery, since such records can 'follow' a patient across sites and systems, supporting some of the defining qualities of primary care: continuity of care (particularly for chronic conditions), comprehensiveness (for prevention and treatment), and patient-centeredness.

Communication is an essential component of efforts to improve health information and should target policy makers and those who are in a position to influence policy makers such as academics, researchers, health professionals, parliamentarians, advocacy groups and the media. Communication channels can include seminars, peer reviewed journals, special events, national and international meetings, and policy briefs.

ANNEX

Annex 1
Conference Organizing Committee Members


Prof. Dr. Vicham Panich
Chairman
Mahidol University Council
Nakhon Pathom, Thailand
Chair

Dr. Ian Smith
Advisor to the Director-General
World Health Organization
Geneva, Switzerland
Co-Chair

Dr. Toomas Palu
Lead Health Specialist
The World Bank
Phnom Pehn, Cambodia
Co-Chair

Dr. Prat Boonyavongvirot
Permanent Secretary
Ministry of Public Health
Nontaburi, Thailand
Member

Mr. Virasakdi Futrakul
Permanent Secretary
Ministry of Foreign Affairs
Bangkok, Thailand
Member

Dr. Supat Vanichakarn
Secretary - General
Prince Mahidol Award Foundation
Bangkok, Thailand
Member

Dr. Sanguan Nittayarumphong
Secretary - General
National Health Security Office
Bangkok, Thailand
Member

Dr. Julian Lob - Levyt
Executive Secretary
GAVI Alliance
Geneva, Switzerland
Member

Dr. Michel Kazatchkine
Executive Director
The Global Fund to fight AIDS,
TB and Malaria
Geneva, Switzerland
Member

Dr. Sally Stansfield
Executive Secretary
Health Metrics Network
Geneva, Switzerland
Member

Dr. Francis Omaswa
Executive Director
Global Health Workforce Alliance
Geneva, Switzerland
Member

Dr. Myint Htwe
Director, Programme Management
WHO/SEARO
New Delhi, India
Member

Dr. Richard Nesbit
Director, Programme Management
WHO/WPRO
Manila, Philippines
Member

Dr. JVR Prasada Rao
Director,UNAIDS Regional
Support Team for Asia and
the Pacific UNAIDS
Bangkok, Thailand
Member

Dr. Piyasakol Sakolsatayadorn
President
Mahidol University
Nakhon Pathom, Thailand
Member

Dr. Pornchai Matangkasombut
Former President
Mahidol University
Nakhon Pathom, Thailand
Member

Dr. Pongpisut Jungudomsuk
Director
Health Systems Research Institute
Nontaburi, Thailand
Member

Dr. Phitaya Charupoonphol
Dean, Faculty of Public Health
Mahidol University
Bangkok, Thailand
Member

Dr. David de Ferranti
Chairman
Health Financing Task Force
Washington, D.C., USA
Member

Dr. Ariel Pablos-Mendez
Managing Director
The Rockefeller Foundation
New York, USA
Member

Dr. Hani Serag
Global Secretariat Coordinator
People's Health Movement
Cairo, Egypt
Member

Dr. Suwit Wibulpolprasert
Senior Advisor on Disease Control
Ministry of Public Health
Nontaburi, Thailand
Member & Secretary

Dr. Viroj Tangcharoensathien
Director, International Health
Policy Programme
Ministry of Public Health
Nontaburi, Thailand
Member & Asst. Secretary

Dr. Churnrurtai Kanchanachitra
Vice President
Mahidol University
Nakhon Pathom, Thailand
Member & Asst. Secretary

Dr. Wanchai Wanachiwanawin
Professor
Faculty of Medicine Siriraj Hospital
Mahidol University
Bangkok, Thailand
Member & Asst. Secretary

Dr. Sopida Chavanichkul
Director, International Health
Bureau Ministry of Public Health
Nontaburi, Thailand
Member & Asst. Secretary

Dr. Pongsadhorn Pokpermdee
Medical Officer
Office of the Permanent Secretary
Ministry of Public Health
Nontaburi, Thailand
Member & Asst. Secretary

Annex II

List of Speakers, Panelists, Co-Chairs and Rapporteurs

Session	Speakers	Panelists
Keynote Speech		
Thirty Years of PHC: Discern the Past, Understand the Present and the Way Forward	Anarfi Asamoa-Baah Joy Phumaphi Sanduk Ruit	
Panel Session		
Primary Health Care: Past Achievement, Future Challenges and Responses: Five Country Case Studies	Toomas Palu	Paulin Basinga Fran Baum Komatra Chuengsatiansup Tedros Adhanom Ghebreyesus Julian Schweitzer Viroj Tangcharoensathien Lo Veasnakiry Robert Woollard
Parallel Session 1		
Who Services Primary Health Care and How They Can Be Effectively and Equitably Created, Motivated and Maintained to Provide Good PHC Services?	Manuel Dayrit Sultana Khanum Srinath Reddy Badara Samb Miriam Were	Sigrun Mogedal Ravi Narayan Francis Omaswa
Parallel Session 2		
PHC and Public Health Surveillance and Response	Stella Chungong Hamid Jafari Holly Ladd, JD Ahmed Tayeh Terence Taylor	
Parallel Session 3		
Impact of Global Health Initiatives on PHC and their Contribution to Strengthening Health Systems	Prerna Banati Badara Samb David Sanders	Kathy Cahill Raj Kumar Bernhard Schwartlander Julian Schweitzer
Parallel Session 4		
International Trade, Trade Agreements and Health: Implications on Primary Health Care	Frederick M. Abbott Choy Lup Bong Bounpheng Philavong Pierre Sauve Sripen Tantivess Elisabeth Tuerk David Vivas-Eugui	Santiago Alcazar Sameen Siddiqi

Co-Chairs	Rapporteurs
	William M.Honsa, Jr Pornchai O-Charoenrat
Timothy Evans Ariel Pablos-Mendez Lincoln Chen (Moderator)	Jeffrey Johns Adrian Ong Siriwan Pitayarangsarit
Keizo Takemi Wang Longde	William Aldis Thinakorn Noree Nonglak Pagaiya Susan Rifkin Dean Shuey
David Heymann Myint Htwe	Amanda Glassman Melinda Moore Wichai Techasatit Chanwit Tribuddharat Kumnuan Ungchusak
Manto Tshabalala-Msimang Marie-Odile Waty	Lee Nah Hsu Philip Guest Walaiporn Patcharanarumol Pungpond Rukumnuaykit
Nick Drager Fadia Saadah	Wiliam Aldis Juthamas Arunanondchai Chantal Blouin Benedikte Dal Nusaraporn Kessomboon

Annex II

List of Speakers, Panelists, Co-Chairs and Rapporteurs

Session	Speakers	Panelists
Parallel Session 5		
Financing PHC: Allocating Resources for Improved Effectiveness and Equity	Rifat Atun Amanda Glassman Pablo Gottret Ahmad Jan Naeem	Anne Mills Ammar Siamwalla Adam Wagstaff
Parallel Session 6		
Evidence, Information for Health Systems Strengthening in Support of PHC	Carla AbouZahr Thomas Inui Clifford W. Kamara Hani Serag Crispinita Valdez Lo Veasnakiry Pepela Wanjala	Virasakdi Chongsuvivatwong
Conference Synthesis		
Summary, Conclusion and Policy Recommendations	Adrian Ong Toomas Palu Viroj Tangcharoensathien	
Commemoration Ceremony		
	Mongkol Na Songkhla Samlee Plianbangchang Supachai Panitchpakdi	

Lead Rapporteur Team

Jeffrey Johns
Adrian Ong
Toomas Palu
Viroj Tangcharoensathien

Co-Chairs	Rapporteurs
David de Ferranti Emmanuel Jimenez	Supon Limwatananon Marty Makinen Pongsadhorn Pokpermdee Kavita Sivaramakrishnan Samrit Srithamrongsawat
Abdul Azeez Yoosuf Phillip Hay (Facilitator)	Carla AbouZahr Wichai Aekplakorn Kanitta Bundhamcharoen Pinij Faramnuayphol Waranya Teokul
Anarfi Asamoa-Baah	

Prince Mahidol Award Conference Secretariat Office
Institute for Population and Social Research

Mahidol University
Salaya, Phutthamonthon, Nakhon Pathom 73170, Thailand
Tel: (66) 2441-0202 ext. 139 or 140 Fax: (66) 2441-9333

E-mail: pmaconference@mahidol.ac.th
www.pmaconference.org