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# **The role of first-line hospitals**

## **Needs and challenges in a changing environment**

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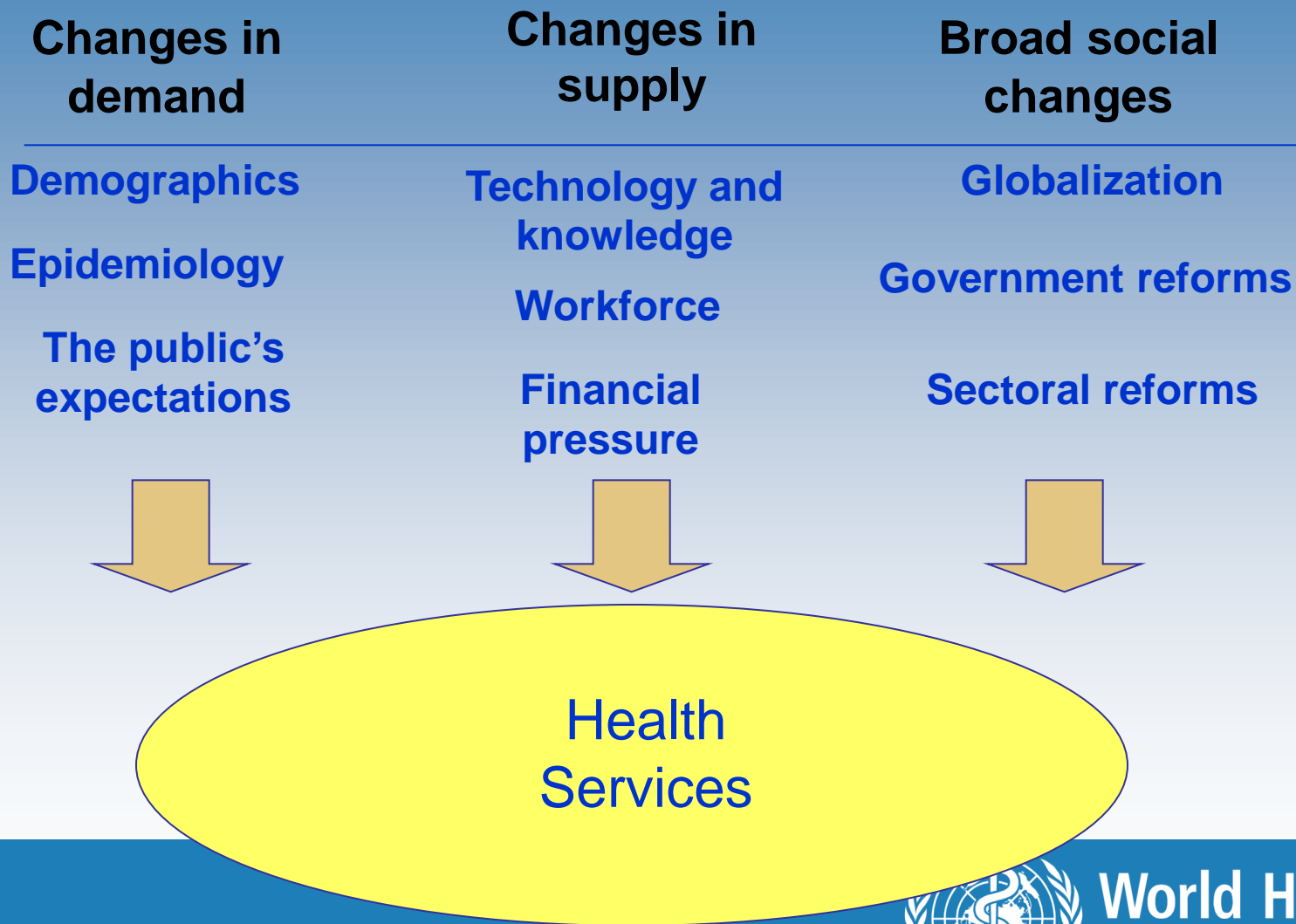
# Introduction

- The changing context of Primary Health Care renewal
- What are the major issues for the future?
- What models of health care delivery services will be needed?
- What will be the role of hospitals?
- Identified gaps and proposed actions to be taken



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# Pressure for Change on Health Services



# Transformation of the Health Paradigm

<b>Old Paradigm</b>	<b>Emerging Paradigm</b>
<b>Responsibility for individuals</b>	<b>Responsibility for the health of defined populations</b>
<b>Emphasis on care of acute episodes of disease</b>	<b>Emphasis on care throughout the continuum</b>
<b>The service providers are essentially equal</b>	<b>Differentiation based on the capacity to provide added value</b>
<b>Success is measured by the capacity to increase hospital admissions</b>	<b>Success depends on increasing coverage and capacity to maintain people healthy.</b>
<b>The objective of the hospitals is to fill beds</b>	<b>The objective of the network is to provide the appropriate care at the appropriate level</b>
<b>Insurers, hospitals, ambulatory centers, work separately (Fragmentation)</b>	<b>Networks of Integrated Delivery Services (IDS)</b>
<b>Management of isolated organizations</b>	<b>Management of networks</b>

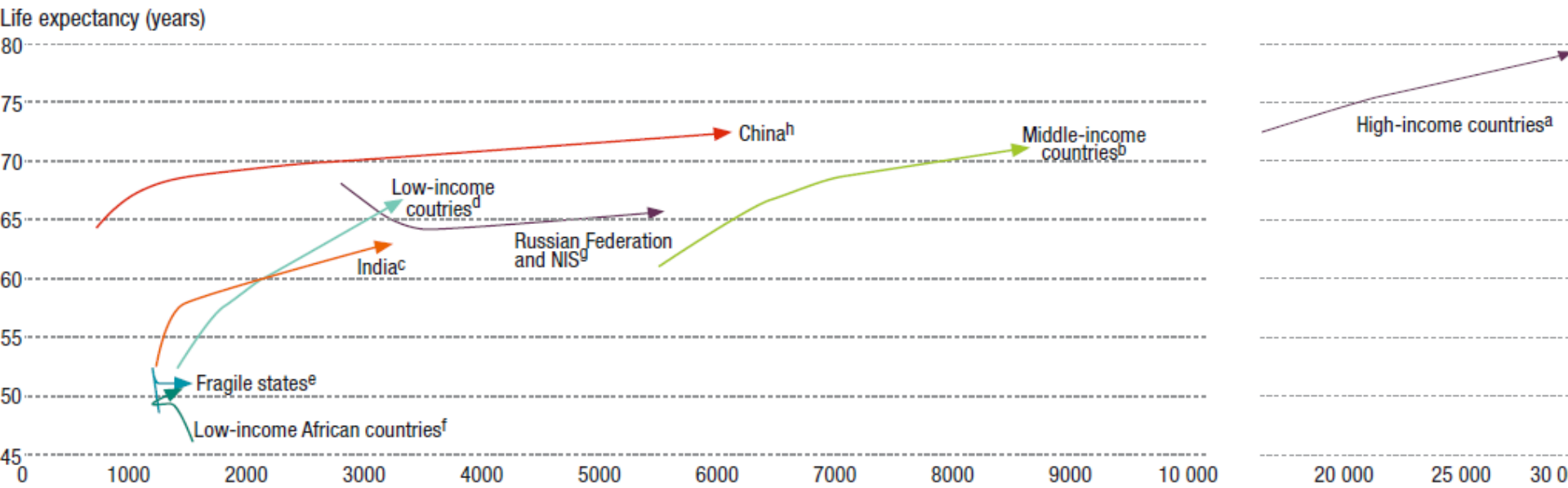
**Table 1** How experience has shifted the focus of the PHC movement

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT CONCERNS OF PHC REFORMS
Extended access to a basic package of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
Concentration on mother and child health	Dealing with the health of everyone in the community
Focus on a small number of selected diseases, primarily infectious and acute	A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses
Improvement of hygiene, water, sanitation and health education at village level	Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards
Simple technology for volunteer, non-professional community health workers	Teams of health workers facilitating access to and appropriate use of technology and medicines
	⋮
Primary care as the antithesis of the hospital	Primary care as coordinator of a comprehensive response at all levels
PHC is cheap and requires only a modest investment	PHC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives

# Why PHC?

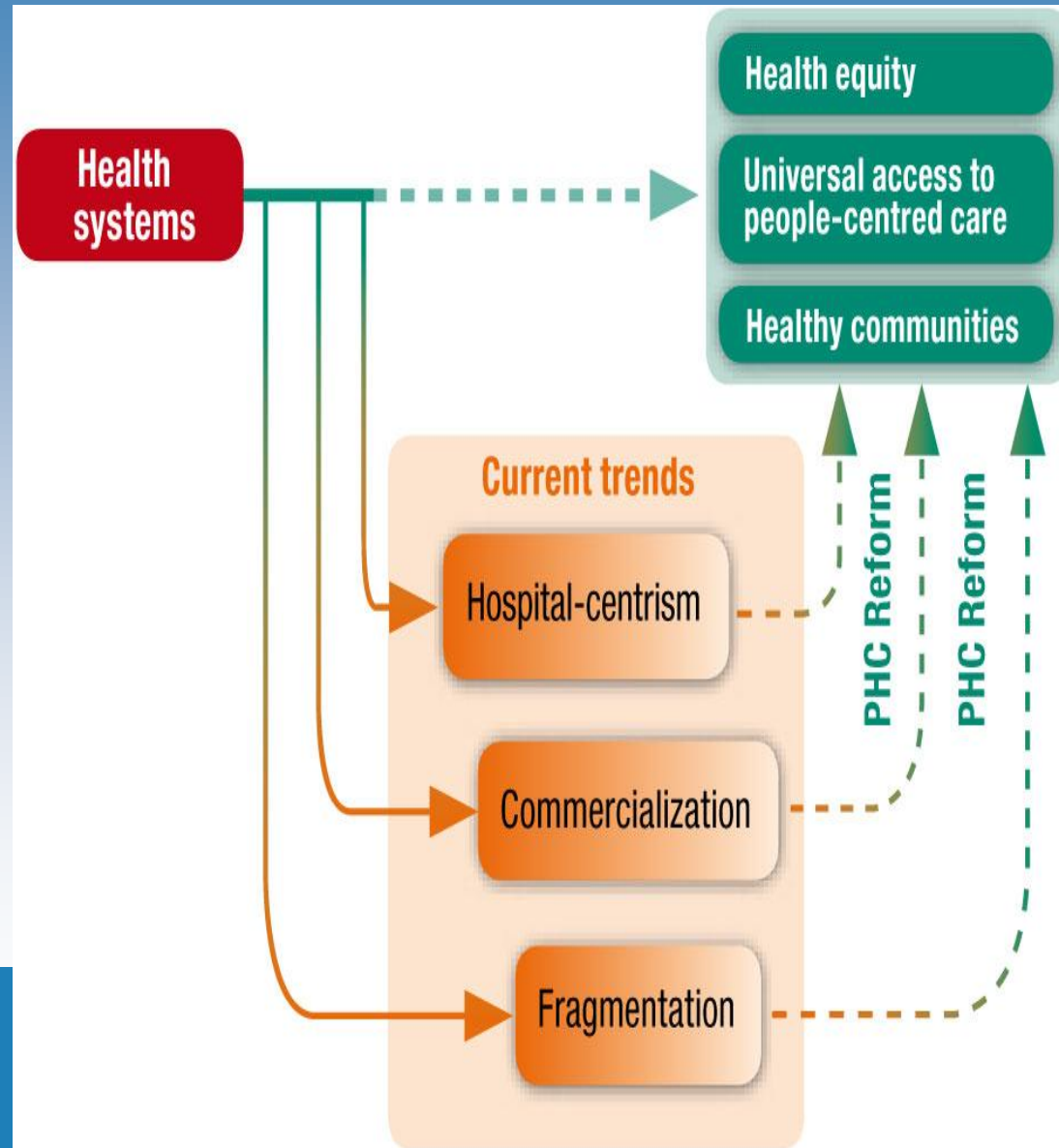
- Demographic and epidemiological changes
- Profound political, economic, social and cultural changes
- Unfinished agenda: inequities, social exclusion.....
- Accumulation of lessons learned and good practices
- Advances in science, information and communication technologies

Figure 1.5 Trends in GDP per capita and life expectancy at birth in 133 countries grouped by the 1975 GDP, 1975–2005\*

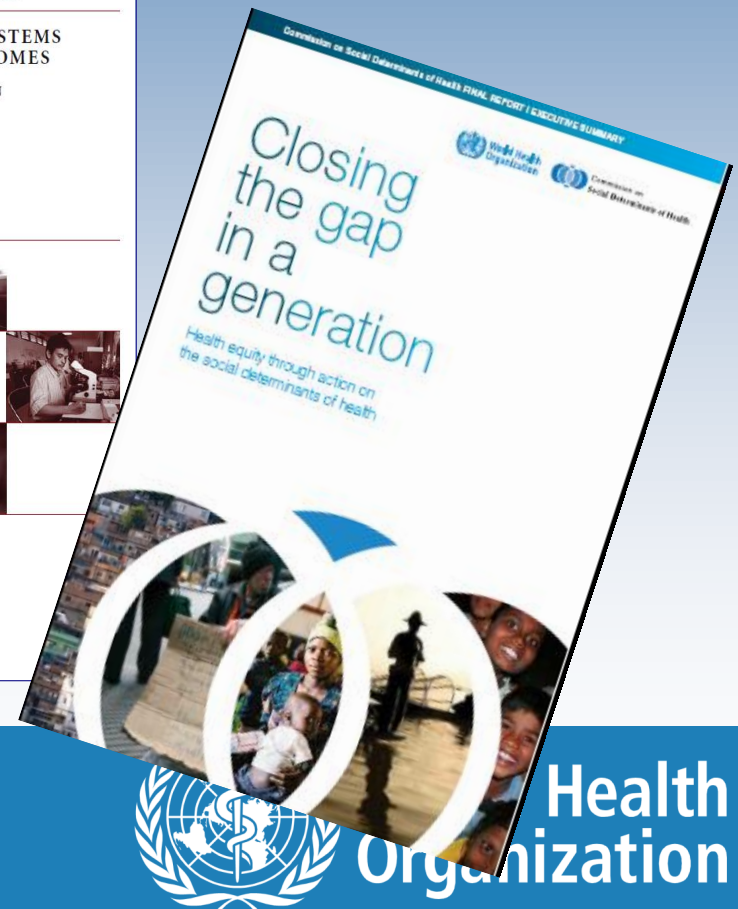
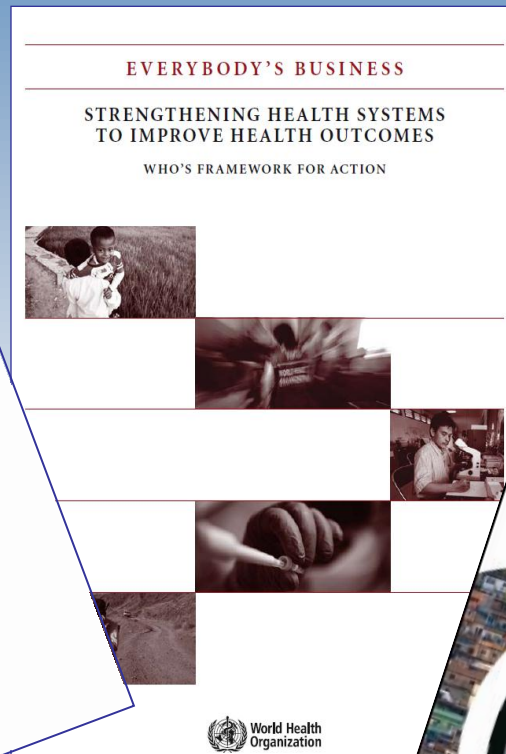


# Why PHC?

- Evolving health needs and challenges
- Meeting MDGs
- Revival of values-based approaches
- Fragmentation and inequity
- Unmet expectations
- Financial crisis



# Convergence of equity and health systems agendas



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# Linking PHC-Based Health Systems with other Determinants of Health through:

- Healthy public health policies: *Health in All Policies*
- Emphasizing equity
- Social protection
- Intersectoriality
- Health promotion and participation
- Human rights
- Gender, ethnic and intercultural approaches to social services



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# The benefits of PHC

- Improved health outcomes at the population level
- Improved equity in health outcomes and access to health services
- Better efficiency of the health system as a whole, less costs
- More satisfaction of users with health services



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# PHC–based health system

- a **PHC–based health system** entails an *overarching approach* to the organization and operation of health systems that makes the *right to the highest attainable level of health* its main goal while maximizing *equity and solidarity*.



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# Primary health care renewed: 4 sets of reforms



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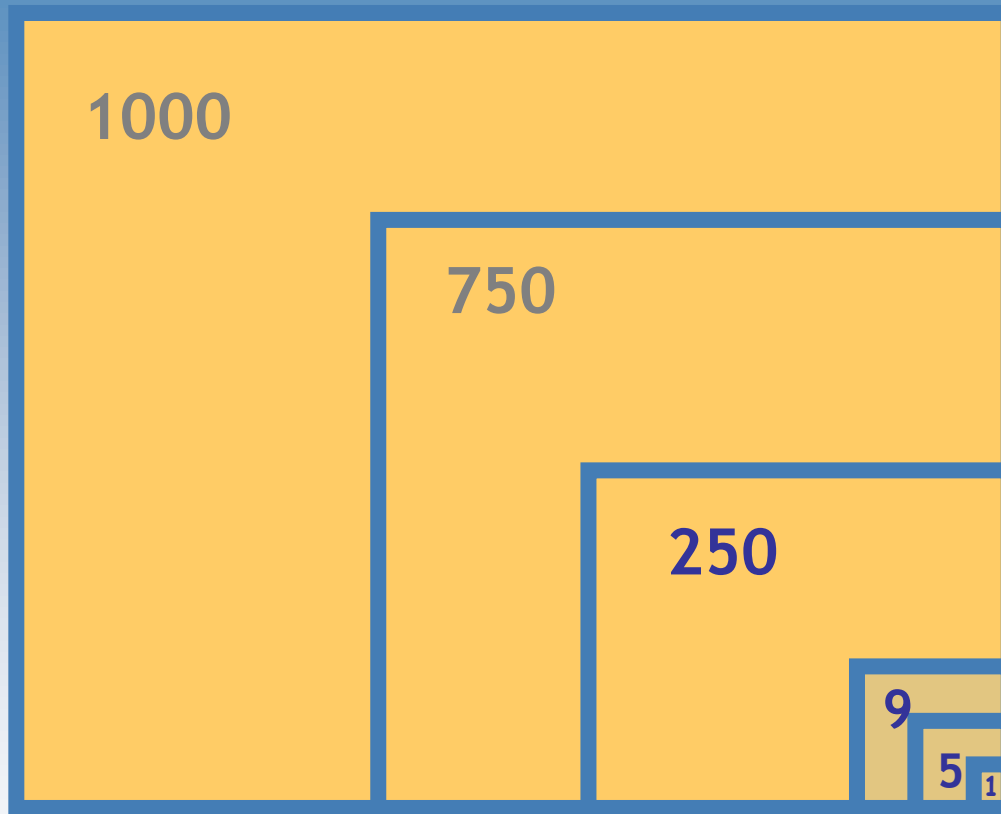
# What do people want?

- To live long healthy lives
- To be treated fairly and equitably
- To have a say in what affects their lives and that of their families
- To be regarded as human beings and not just "cases"
- Reliable health authorities
- Reduced risk of disease
- Effective medicines and technologies
- Efficient services



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# (Renewed) primary health care paradigm



9 admitted to DH

5 referred to other doctor

1 went to tertiary

*In Europe, >90 % of encounters are at Primary Care level* [BMJ, 2009]

Kerr White, NEJM, 1961



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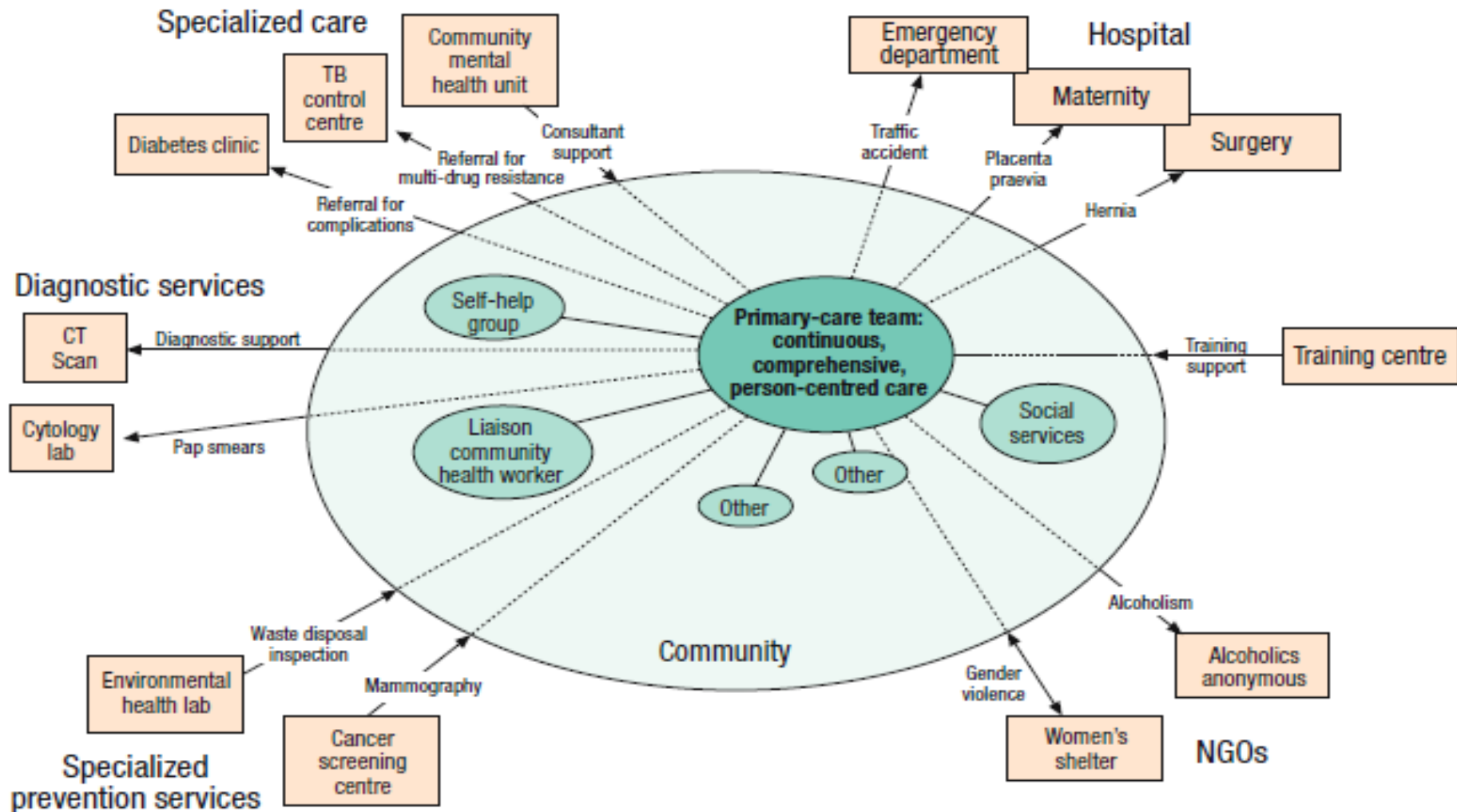
# Major issues for the future

1. Increase incidence of chronic conditions and co-morbidities
2. Lifestyle changes influencing diseases patterns
3. Co-existence of unsolved preventable, emerging, and neglected diseases
4. Increase in the quantity and quality of the demand
5. Technological drivers
6. Population changes



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# Primary care as a hub of coordination with hospitals roles and services





**Table 3.1** Aspects of care that distinguish conventional health care from people-centred primary care

<b>Conventional ambulatory medical care in clinics or outpatient departments</b>	<b>Disease control programmes</b>	<b>People-centred primary care</b>
Focus on illness and cure	Focus on priority diseases	Focus on health needs
Relationship limited to the moment of consultation	Relationship limited to programme implementation	Enduring personal relationship
Episodic curative care	Programme-defined disease control interventions	Comprehensive, continuous and person-centred care
Responsibility limited to effective and safe advice to the patient at the moment of consultation	Responsibility for disease-control targets among the target population	Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health
Users are consumers of the care they purchase	Population groups are targets of disease-control interventions	People are partners in managing their own health and that of their community



# 1. What implications can we envisage for hospitals?

Hospitals should:

- contribute to improving health and reducing inequalities, as part of the wider health systems
- provide a highly valued ‘rescue’ function for life-threatening conditions, and can improve outcomes from treatment by concentrating technology/expertise where necessary [IPPR, 2007]
- will no longer be the centre of the system or stand alone, most likely part of a “one stop shop” that includes primary care, specialized out-patient care, and diagnostic services (network)
- will be more open to the community and to the other members of the network including social services.



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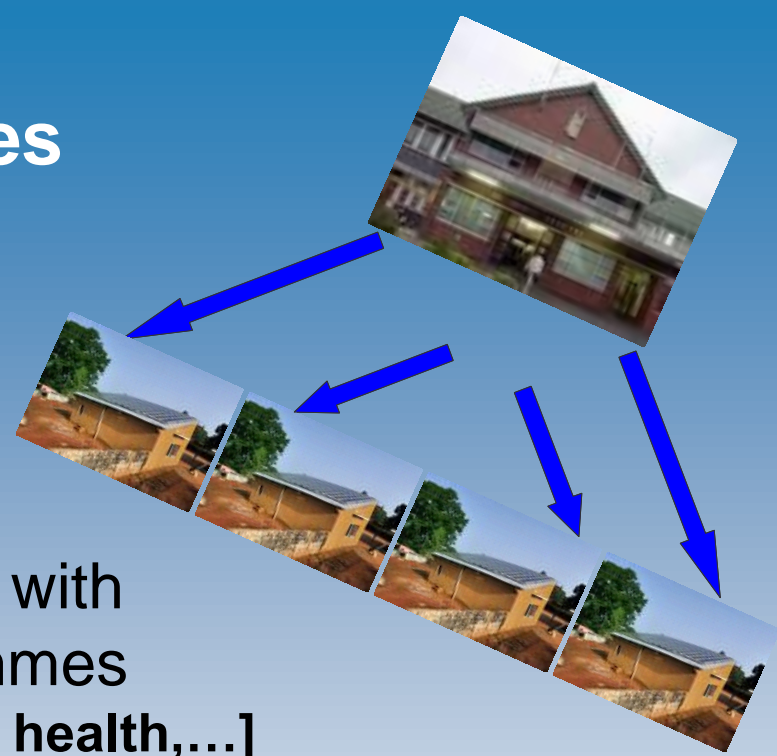
# Organization of services

- Hospital as part of health care networks to fill the availability gap of complementary referral care: giving primary-care providers the responsibility for the health of a defined population, in its entirety
- Hospital should not be an entry point: relocating the entry point to the health system from hospitals and specialists to close-to-client generalist primary-care centres;
- Strengthening primary-care providers' role as coordinators of the inputs of other levels of care by giving them administrative authority and purchasing power



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# Organization of services



## Integration:

- integrated care: complementarities with requirements of specialized programmes [HIV/Aids, tuberculosis, maternal & child health,...]
- no gap and no overlap between first and second level of care
- in many settings primary care professionals are working in isolation and so are doing the doctors in hospitals



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# Organization of services

“The importance of hospital-based care will not diminish in the future”

Joint Commission International, 2008



But, delicate balance:

- between people centeredness and technological requirements
- over and under spending with high risk of error repetition
- between lobby of equipment and pharmaceutical industry and social aspects of equity and inclusiveness/participation



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# Financing

Hospital costs are higher compared to primary care. It does not mean that hospitals are inefficient. It all relates to their roles and responsibilities

Indicator	Country	%	US\$/inh. /year	Source
% of total HE	USA (2005)	31	2500	Health Affairs, 2007
% of expenditure at rural district level	Indonesia (2007)	43	2.5	Health Research Policy and Systems, 2009
Estimated cost of CPA vs MPA	DRC (2008)	65	12	iHTP / MoH calculations (WHO, 2009)

# Improved intersectoral actions

- Hospitals are responsible for household catastrophic health expenditure ☒ effective health insurance
- New [commercial] arrangements that make additional financial resources available (private sector, China, India, Brazil,...)  
☒ new policy dialogue and increased intersectoral role for MoH and WHO



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## 2. Some gaps to be filled...

Administrative aspects: Coverage of a territory

Health care Functions: Exclusive and/or shared functions? How to adapt existing facilities which do not fit with models?

Redefining packages of activities and levels of decision making/coordination/regulation





# Some gaps to be filled...

Identifying and sorting the driving forces: public or private based market? Recognizing the value of integrated networks especially in urban settings

Complementarities with primary care: within and across countries diversity and complexity of referral mechanisms (classification of hospitals, pyramid models,...)



## 2. Pistes de réflexion pour l'action: managing change in designing better hospitals

Restructuring hospitals: meet legitimate expectations, improve clinical outcomes, incorporate flexibility,...

Standardization of hospital practices (80/20) taking a life cycle viewpoint in a systemic perspective

Ensure better quality, value for money and sustainability of capital investment

Investing in health workforce, inclusive planning and expanded evidence base

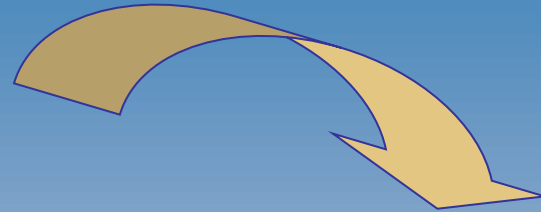


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# Pistes de réflexion pour l'action: Reconsider role and functions

Importance of **flexibility** for provision of service:

- usefulness of hospital-centered health systems
- should end user perspective be dominant?
- responses must be adapted to financing models
- responses may vary in format within and across countries



Multiplicity of ways to provide services but unique objectives:

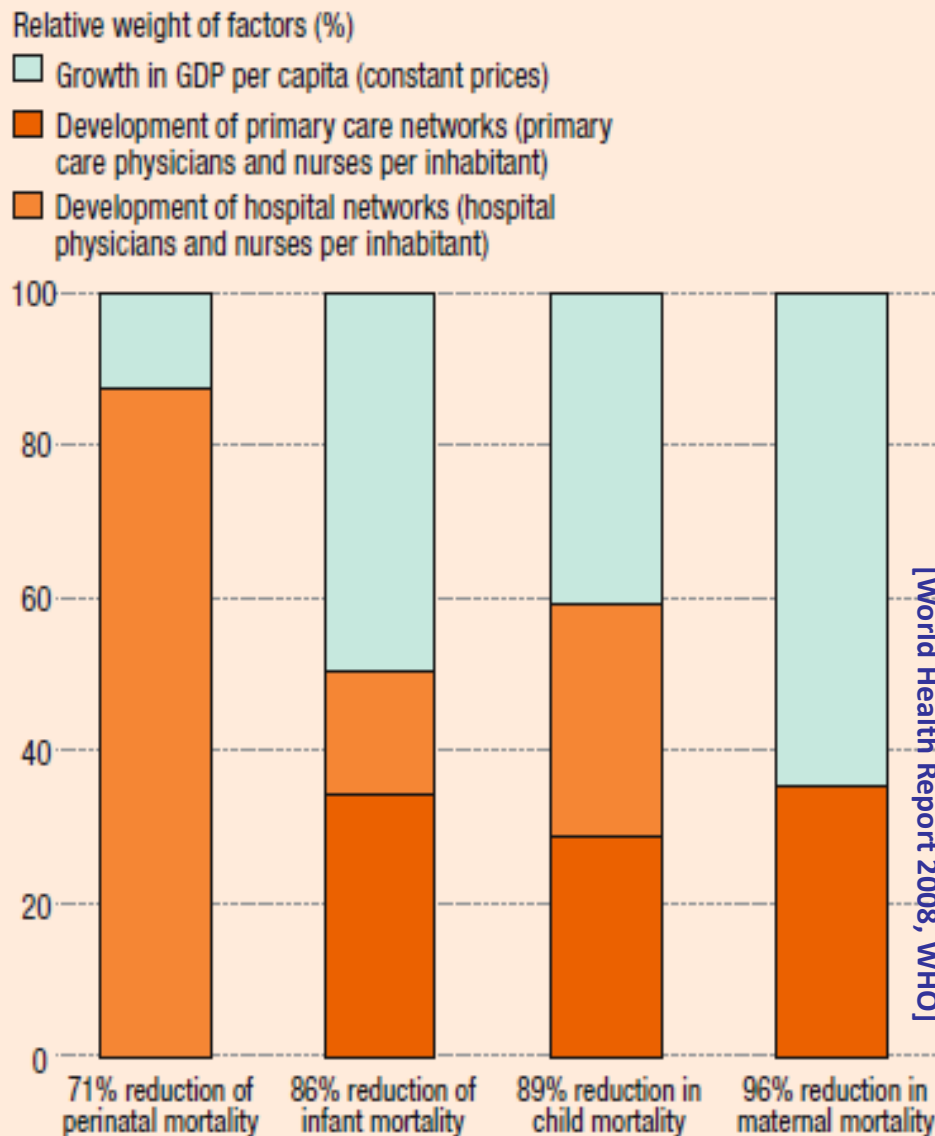
- accessibility
- efficiency
- quality of care
- responsiveness
- fairness in financing

Adapted from De Roodenbeke, 2009



# Pistes de réflexion pour l'action: Reconsider outcomes measurements

Figure 1.2 Factors explaining mortality reduction in Portugal, 1960–2008



Hospital care is important for health status improvement but this is not an end:

- hospital functions
- healthcare network responsibilities
- effective continuum of care over the lifespan

**Importance of  
outcome indicators**

Adapted from De Roodenbeke, 2009



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# Pistes de réflexion pour l'action: planning and regulation

Better shaped health information system for improved information-based decision making

Improved Governance:

- norms and rules for opening activities,
- norms and rules for HS strengthening (drugs, HR,...)
- stewardship by national authorities and stakeholders,
- coordination of aid

National health plans: should integrate hospital sector reforms,



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### 3. What do we need for the future?

- Define functions of hospitals (specialized services)
- Redefine the role of hospitals in a better balanced health system
- Are there successes to be reported on hospital reforms throughout the world?
- What is the potential role of WHO?
- What is the role of the international community? (IHF, ACHE, JCI, WB,...)



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