Primary Health Care: the building block of Universal Health Coverage

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Issue#12 November 2018

policy brief

The importance of Primary Health Care (PHC)

The World Health Organization in 1978 (WHO 1978) advocated for primary health care (PHC) as a strategy to achieve Health For All (HFA) by the year 2000. This abstract goal of HFA was made more concrete at the turn of the millennium when the broader set of the Millennium Development Goals (MDGs) to be achieved by 2015 were defined (UN 2000). Subsequently, the Sustainable Development Goals (SDGs) enshrined the goal of achieving universal health coverage (UHC) by 2030 (UN 2015). Various resolutions from UN General Assemblies and the WHO advocate for progressive realization of UHC by all member states as a vehicle to achieve health related SDGs.

The push for UHC has been accompanied by PHC roadmap strategies to achieve the health-related targets (WHO 2008). PHC has been tested, adjusted, and redefined by country realities as countries sought universal coverage, focusing not only on the poor or rural people but the entire population (see table 1). PHC supports the goal of 'health for all' by acting as the first point of contact for patients and by providing care that is both family and community oriented, taking into account the critical influences of both these social networks, and providing services that are well-coordinated and ensure continuity of care. An effective PHC system facilitates equitable access to quality health services with better health outcomes at a reasonable cost to the individual and the country.

Table 1: Shift in focus of primary health care

Primary health care 1978	Primary health care 2008
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
PHC is cheap and requires only modest investment	PHC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives

Adapted from WHO (2008)

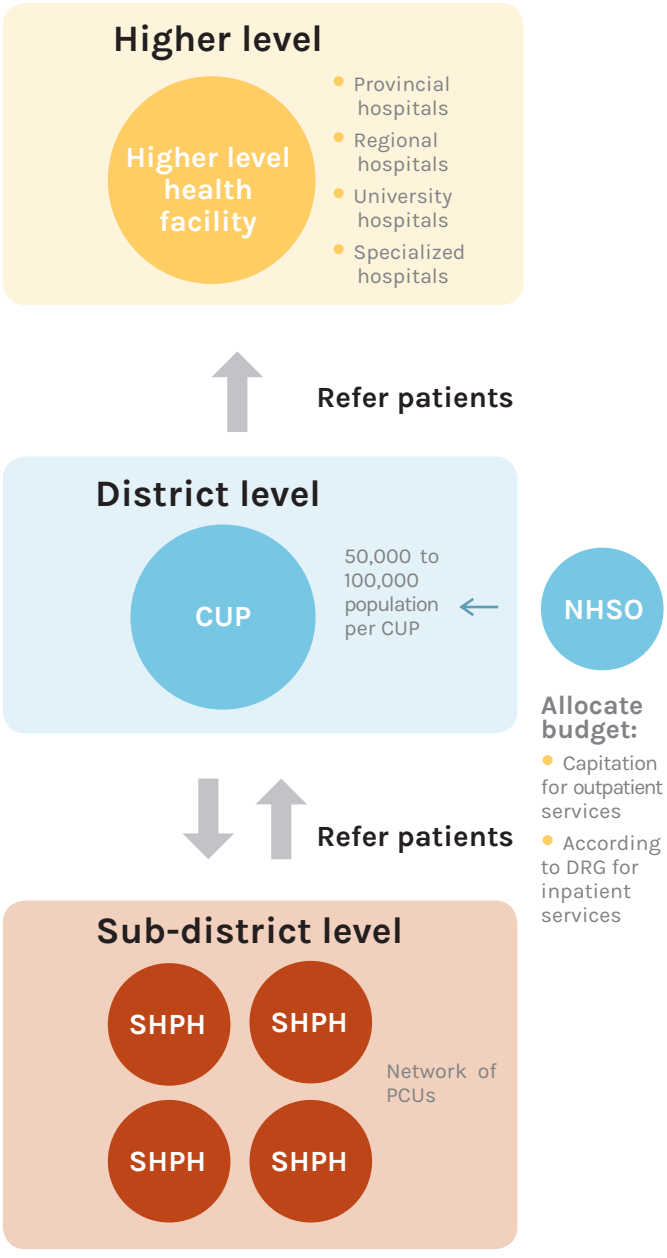
In tracking progress towards UHC, the WHO categorizes countries into three groups: the advanced, the moderate and the lagging behind. These groups are defined according to health service coverage, financial protection and health outcomes (WHO 2017). However, countries that have well-integrated PHC systems throughout the entire health care system have demonstrated effects on health outcomes and equity (Starfield et al 2008). Thailand is one such example where strengthening of the PHC system, even with limited resources and moderate progress on UHC indicators, has enabled the country to achieve UHC.

The context and historical development of PHC in Thailand

The ratio of trained human resources to population is critical in the delivery of effective PHC and may place a binding constraint on the degree of UHC that can be achieved. Thailand demonstrates exemplary records in PHC implementation as it appointed 700,000 village health volunteers for a population of 60 million (1 Village Health Volunteer per 85 persons) in order to ensure the extension of scarce health services to all Thai people, including those in rural areas (Primary Health Care Division 2014).

In 2001, three key transformations took place in the field of new health care financing, new budget allocations, and a new health care delivery model for the Universal Coverage Scheme (UCS) strengthened PHC reforms and service delivery (Nitayarumphong 2006). The UCS has since provided better access to cost-effective health packages, from basic health service items like immunization at sub-district health promoting hospital (SHPH) to high cost care like heart surgery, cancer treatment, or kidney transplantations delivered at tertiary hospitals with zero copayment at point of service, resulting in a high level of financial risk protection and preventing financial hardship from use of health services.

Financing reform started with capitation payment as a major provider payment method to the lowest health facility that can provide comprehensive primary care and public health services. The term "contracting unit of primary care" (CUP) was first used to describe an entity of service unit that covers registered populations of around 50,000 to 100,000 per main contractor at district level (usually a community or district hospital acts as CUP in rural area). The CUP plays a gatekeeper role and inhibits bypassing registration to higher levels of health facilities in the UCS. The main contractor subsequently assembles a network of primary care units (PCUs) to provide better access to health services to the registered population at the sub-district level (SHPH acts as PCU). The National Health Security Office (NHSO) was set up in 2002 as a purchaser of health services for the UCS. The NHSO allocates the capitation budget to CUPs to cover outpatient service according to registration size with age adjustment, and allocates a separate inpatient budget to hospitals according to diagnosis-related group (DRG) of hospitalized patients with the global budget (GB) or the available budget ceiling for inpatient expenditure to contain the total cost of the UCS. The Ministry of Public Health (MOPH) remains responsible for delivering public health services on disease prevention and control, and therefore, continues to manage the overall public health budget. (See Figure 1)



CUP: contracting unit of primary care
DRG: diagnosis-related group
NHSO: National Health Security Office
PCU: primary care units
SHPH: Sub-district health promoting hospital
Note: CUPs can be set up at other levels based on the management, e.g. urban district area

Figure 1: Contracting unit of primary care (CUP)

The PHC structure in urban areas including the Bangkok Metropolitan Administration (BMA) was less developed and differed from rural settings where municipalities were responsible for provision of PHC for the local communities. The government PCUs in urban cities are small and have lower capacity to respond to health needs of urban populations. This is in spite of the presence of big public hospitals (under the MOPH and other ministries, including teaching hospitals of the Ministry of Education), big private hospitals, private clinics and pharmacies in cities. In urban areas, with the NHSO's purchasing design, big public and private hospitals can act as CUPs and form the PCU networks with either public or private clinics. Under the contractual agreement, the NHSO pays a capitation budget to CUPs only, and it is up to the CUP to set specific payment arrangements and rates to its affiliated PCU network for services utilized by the population registered with the CUP. This model creates opportunity for the primary care team to reach a concentrated population in urban areas.

A survey of policy makers responsible for primary health care and primary care practitioners on primary care attributes[1] of selected services[2] found that the PHC system delivered favorable outcomes in terms of achieving equity but had questionable outcomes in terms of quality (Pongpirul et al 2012). Successive public health ministers have been advocating for improvements in the quality of primary care teams that are led by well-trained family medicine specialists. The 2017 Constitution of Thailand endorsed a "family doctor policy " whereby each Thai citizen is attached to a well-trained family practitioner with an outreach team. This policy also targeted having an appropriate family doctor to population ratio. This approach has been branded as the 'primary care cluster' (PCC) policy and recently replaced the brand of 'primary care teams' (PCTs), which emphasized the role of teams delivering services. As part of the PCC policy, a few PCUs were merged into a larger cluster in an attempt to increase capacity and quality of care within a cluster. The rapid "brand " changing has been criticized by family practitioners as too being too closely affiliated with political figures rather than fostering the spirit of PHC (Khonthaphakdi et al 2018).

The UCS health system described above covers almost 75 percent of the Thai population, which is managed by the NHSO whereas the Civil Servant Medical Benefit Scheme (CSMBS) covers 8 percent and the Social Security Scheme (SSS) insures 16 percent of the total population. This means that about 24 percent of the population covered by the CSMBS and SSS have different arrangements for PHC as compared to the UCS. The CSMBS does not apply any gatekeeping rule and incurs high outpatient expenditure due to its fee-for-service reimbursement system whereby all primary care services are provided by tertiary and university hospitals. The Social Security Office, which manages the SSS, on the other hand, contracts "big " hospitals (public or private with 100 beds or larger) as main contractors for outpatient and inpatient services (or inclusive capitation contract). The Social Security Office leaves the decision with these hospital contractors to arrange their own PHC providers through sub-contractual agreement with private clinics.

In terms of health expenditure per capita, the UCS managed by the NHSO spends the least while the CSMBS is the highest spender (at least four times per capita spending higher than UCS), driven by the fee-for-service payment system for outpatient care. With a limited budget subsidy from the government, the considerations of introducing new cost-effective interventions into the UCS benefits package applies the most explicit health technology assessment mechanism. The Health Intervention and Technology Assessment Program (HITAP) is one of the key players involved in drafting recommendations for the National Health Security Board to include new interventions in the UCS benefits package. The process of reviewing evidence takes place within the NHSO management if the UCS benefits package is being reviewed, or within the National Essential Drug Committee mechanism, if the policy decision involves the three schemes. Once accepted into the benefit package, service arrangements with PHCs and integrated health systems, including the information system to facilitate payment, are put in place.

Once the CUP and PCU receive their capitation budget from the NHSO, they have autonomy to spend the budget for the benefit of holistic health and well-being of the registered population such as self-help, patient interest group for chronic diseases. The CUPs with a larger population have the capacity to pool their risk and use the resulting surplus funds to create innovative essential services such as community rehabilitative care, long term care and palliative care. Moreover, the CUP may receive additional capitation budget when the NHSO extends benefits already included in the core package or makes changes to payment rules. A CUP or PCU may be paid on a fee-for-service basis with the aim of increasing service delivery. Examples of these type of services are home visits to offer rehabilitation for stroke patients and achieving a quality target such as high coverage of cervical cancer screening within a quality-outcome framework (QOF).

[1] Resource allocation, adequacy of resources, copayment requirements, comprehensiveness of care, first contact, longitudinality, coordination, family-centeredness, community orientation, and professional personnel.

[2] Vaccinations for children; illnesses care for children, adults and the elderly; prenatal care/safe delivery; family planning services; care of sexually transmitted diseases; treatment of tuberculosis; treatment of minor injuries; counseling about alcohol and tobacco use; minor surgery; non-major mental health problems; care for chronic illness; health education; screening/treatment of parasitic diseases; nutrition program; school-based services

Key lessons for other countries ("do's and don'ts")

The PHC experience in Thailand sheds light on the do's and don'ts for other countries as follows:

Do's

- Emphasize the importance of integration of PHC (public health plus primary care) with the country health systems. It is the role of the Ministry of Public Health to oversee effective integration for maximizing health outcomes and equitable access to quality health services.
- Set targets for the population to be covered by each PCU provider in order to achieve full coverage in rural and urban areas. The target indicators should not only include quantity of services provided but also address the quality of services such as short- and long-term outcomes.
- Design the population registration system and allow for consumers to choose a provider network.
- Apply a gatekeeper role through strategic purchasing and an effective referral system to contain cost and prevent bypassing of the PHC.
- Offer financial autonomy to PCU providers for utilizing and keeping their capitation budget, that is, exploiting decentralization of efficient management to achieve equity of health outcomes.
- Invest in an information system for catchment population enrolment through health service utilization to monitor successes and failures of the systems.

Don'ts

- Create fragmented insurance schemes to reach different target populations. Fragmentation, or sub-population targeting, is a barrier to achieving equity and ensuring an efficient system.
- Rapidly change the branding of initiatives.

Acknowledgement

This policy brief is a part of a series reflecting on Thailand's experience of implementing universal health coverage. This work has been commissioned by the Health Intervention and Technology Assessment Program (HITAP) under the auspices of the International Decision Support Initiative (iDSI) funded by the Bill & Melinda Gates Foundation, the Department for International Development, UK, and the Rockefeller Foundation.

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Supasit Pannarunothai obtained his MD from Mahidol University and PhD from London School of Hygiene and Tropical Medicine. After retired as professor and dean from Faculty of Medicine Naresuan University, he is now chair of Centre for Health Equity Monitoring Foundation continuing his areas of specialization/ expertise in health equity, health financing and casemix research.