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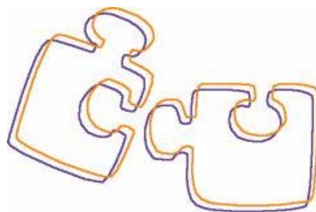
STAKES

The Northern Dimension Partnership for Health and Social Wellbeing



Primary Health Care Expert Group

Planning Workshop

1.-3. February 2005

Helsinki

STAKES

Compiled by Ali Arsalo

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ATTACHMENTS:

1. **Notes of the PHC EG Discussions on February, 1.-3. 2005**
2. **Results of brainstorming for problem identification by countries**
3. **Problem Tree**
4. **Identification of objectives and development needs**

ABBREVIATIONS

BSTF Task Force on Communicable Disease Control in the Baltic Sea Region 2000-2004
CME Continuous Medical Education
FRW Framework
HC Reform Health Care Reform
HIV/AIDS Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
LF Logical Framework
LFA Logical Framework Approach
MDR Multi Drug Resistance
ND Northern Dimension
NDPHS Northern Dimension Partnership for Health and Social Wellbeing
PHC Primary Health Care
PHC PG Primary Health Care Programme Group in the Baltic Sea Task Force
PHC EG Primary Health Care Expert Group in the Northern Dimension Partnership Programme
PHS Partnership in Public Health and Social Wellbeing

DEFINITIONS

The definitions are based on WHO Terminology as published on the Conference on European Health Care Reforms in Ljubljana, Slovenia, 17-20 June 1996, and on the Documents of the Northern Dimension Partnership on Health and Social Wellbeing, Oslo, 22 October, 2003.

Cost effectiveness, an analysis which considers the level of provision of a good or service achieved from a given level of inputs. (WHO Terminology, 1996)

Health system, a formal structure for a defined population, whose finance, management, scope and content is defined in law and regulations, which provides for services to be delivered to people contributing to their health and health care, delivered in defined settings such as in homes, educational institutions, work-places, public places, communities, hospitals and clinics and which may affect the physical and psycho-social environment. (WHO Terminology, 1996)

Northern Dimension in the external and cross-border policies of the European Union reflects the EU's relations with Russia (and particularly North-west Russia) in the Baltic Sea region and Arctic Sea region. The Northern Dimension addresses the specific challenges and opportunities arising in those regions and aims to strengthen dialogue and cooperation between the EU and its member states, the northern countries associated with the EU under the EEA (includes Norway and Iceland) and the Russian Federation. The Northern Dimension is implemented within the framework of the Partnership and Cooperation Agreement with Russia. A particular emphasis is placed on subsidiarity, and on ensuring the active participation of all stakeholders in the North, including regional organizations, local and regional authorities, the academic and business communities, and civil society.

Public health. Science and area of preventing disease, prolonging life and promoting health, through the organized efforts of society. It has a population rather than an individual focus and involves mobilizing local, regional, national and international resources to ensure the conditions in which people can be healthy. (Allin et. al. Making decisions on public health: a review of eight countries. WHO, Copenhagen 2004,11)

Primary Health Care. Essential health care made accessible at a cost the country can afford, with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it. (WHO Terminology, 1996)

Well-being combines the subjective assessment of health both in terms of biological function and self esteem; includes also a sense of social integration. (WHO Terminology, 1996)

LIST OF PARTICIPANTS OF THE NDPHS PHC EG WORKSHOP 1.-3. FEBRUARY, 2005

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INTRODUCTION

This document is the draft report from the planning workshop of the Primary Health Care Expert Group (PHC EG) of the Northern Dimension Partnership for Health and Social Wellbeing (NDPHS), Helsinki 1.-3. February, 2005.

The Report describes briefly the background and some cross-cutting elements of the work, an overall analysis of the most obvious problems and working needs in the field of the PHC EG, as presented during the workshop and the proposal for the future working Mandate for the Group.

The PHC EG approach during the planning workshop, including problem analysis and proposals for the Mandate are based on the framework outlined by the Northern Dimension Partnership Programme.

Background

The Task Force on Communicable Disease Control in the Baltic Sea Region (BSTF) was active in 2000-2004. BSTF contributed to the development of the NDPHS which, on the other hand, came to a new, promising phase on the 13-14th of December in Tallinn where the first meetings of the new Expert Groups were held as side events in connection with the first Partnership Annual Conference.

The PHC EG recognises that its work will be much based on the work done by the PHC Programme Group (PHC PG) within the BSTF. The new expert group understands that in many respects it is continuation of the BSTF activities. The group will consciously build its approaches and practical procedures on earlier experiences and lessons learned as relevant, aiming at an effective start of functions.

Several evaluations have been carried out on the BSTF, its activities and implementation. The PHC PG even carried out an internal assessment *(Arsalo & Vainiomäki, New Approaches for health sector development collaboration in the Baltic Sea and Barents Region, Themes from Finland 2/2004, Stakes)*, the results of which have also been used as background information during the PHC EG planning workshop.

The future tasks of the Expert Group, as presented in this report, reflect the minimum package as seen during the Planning Workshop. However, the Group is not necessary limited to these initial tasks but recognises that, in the future, there may appear needs to widen the target groups or collaboration and the scope of work.

The PHC EG is aware that Health Sector Reforms are currently on-going in all ND countries. However, the role of PHC is recognised in different ways and its role is unclear. In many countries its position is not appropriately defined and it needs much strengthening. Wide gaps concerning primary health and social services between urban and rural areas exist in many areas and basic settings within service systems need much clarification.

Well functioning primary health care is the basis of cost-effective and high quality health system. The PHC EG is aware that no single blue print model exists. One solution cannot be exported as such to another context but each country and region has its specific features to be taken into consideration.

All countries are facing the growing need for additional resources. Reasons are many but in spite of local specific feature, there are also many similarities. Therefore, there is space and need for real multilateral collaboration where new approaches can be developed and projects created to find innovative solutions to produce benefits to all.

Health sector reforms have much concentrated on structural and financial reforms, including introduction of insurance systems. Public health problems, prevention, training for family medicine and establishment of functioning multiprofessional PHC teams have received very limited attention. However, especially public health problems are alarmingly increasing. Gaps in health between different social groups are growing, life expectancy of men especially in Russia is low, many difficult health problems are due to harmful health behaviour and could be easily prevented, and, finally, we are also facing serious communicable disease problems like the spread of HIV and multiresistant tuberculosis.

DESCRIPTION OF THE PLANNING PROCESS OF THE PHC EXPERT GROUP

During the workshop in Helsinki the PHC Expert Group carried out an LFA type identification and planning process. At first, it was stated that the study will focus on the population of the whole ND area, with the perspective of public health, primary health care and health sector reforms.

All participants, as representatives of their countries, organisations or specific substance areas, contributed to the process by expressing their own views of the actual problems and development needs. In the next phase, an open discussion was carried out, trying to identify possible causes and consequences of the expressed problems, within the scope of the Group's approach.

Based on the expressed problems, problem trees were then drafted and analysed. This gave basis for further identification of objectives, working areas and many tasks that should be implemented within the ND area, in order to improve overall wellbeing through the means of primary health care. An objective tree was drafted to show the situation more clearly.

The discussions and drafted problem and objective trees formed the framework for the final phase of the workshop, namely drafting a proposal for future mandate for the Group itself.

LOGICAL FRAMEWORK APPROACH

Logical Framework Approach (LFA) is a participatory bottom-up process for objective oriented project planning, aiming at sustainable development. It is based on the identification of stakeholders and the definition of the main and ultimate beneficiaries, within given scope. Beneficiaries' problems and needs are identified through an open-minded brainstorming, participatory discussions, respect and listening to each other and being honest with oneself.

Problems are analysed, regrouped and organised according to cause-effect relationships. The results of the analysis are presented in a problem tree. It is subsequently used as a tool for more in-depth understanding of the situation and as the basis for identifying and defining objectives, working areas, components, results and activities. It also helps to identify assumptions, risks and cross-cutting elements.

The process and its results decrease the risk for spinal-cord effects or tunnel-visions. It creates common understanding and language among those who are or will be project stakeholders. It provides a tool for ensuring proper justification and relevance of the project. It is also very important that the process can be successfully used for ensuring commitment and ownership of relevant stakeholders.

Finally, the information produced through the objective tree is transferred to Logical Framework Matrix. It presents the hierarchy of objectives, components and activities, indicators, means of verification and assumptions in the form of a 4x4 matrix. The LF matrix can also be used as a tool for the project implementation, budgeting, planning time-tables, distributing responsibilities or monitoring and evaluations.

RESULTS OF THE WORKSHOP

1. Stakeholder identification and definition of Beneficiaries

At the beginning, it was stated and decided that during the workshop will focus on primary health care from a comprehensive perspective, including health care reforms, related primary social services, vulnerable groups, intersectoral views and human resource development.

A rapid identification of key stakeholders and possible beneficiaries was carried out. (Attachment 1). The PHC EG understands that the list is only indicative. A complete stakeholder analysis would need more details and consultations within countries. However, it is an interesting finding that the list of essential stakeholders and beneficiaries resembles each other in all ND PHC EG countries.

The problem identification was carried out assuming that the whole population of the ND Partnership region should be beneficiaries while different special groups, including health professionals, would become beneficiaries of smaller working areas and subsequent individual projects.

2. Problem analysis

At first, problems were identified country by country. See attachment 2. Listed problems were then further studied within the given time frame by recognising their underlying causes. Five major problem areas were identified, concerning
1) policies, legislation and strategies,
2) structures, systems, practical arrangements and management,
3) human resources,
4) communicable and non-communicable diseases, health promotion and disease prevention
5) service provision.

The core problem seems to be that, currently, the provision of primary health and social services do not meet the needs of the people. See attachment 3, Problem Tree.

This problem contributes to serious consequences, due to the facts that equality principle does not materialise, disease burden causes human and economical losses, living conditions of many citizens are unsatisfactory and the existing gaps between different social groups are continuously growing.

3. Setting of objectives and identification of working needs

The problem analysis forms the basis for setting objectives and identifying working needs and activities for the PHC EG itself. See attachment 4, Objective Tree.

The PHC EG will focus on improving public health within the ND PHS region through supporting the development of primary health and social services. Based on equal needs of the people, the work of the EG will aim at providing appropriate services

within the framework of wider health care reforms. This means also special focus on public health, vulnerable groups, prevention of diseases and health promotion.

PROPOSAL FOR THE MANDATE

Primary Health Care Expert Group of the Northern Dimension Partnership for Health and Social Wellbeing (NDPHS PHC EG)

Background

This proposal is based on

1. Request for Expert Group level mandate proposals by the Partnership Secretariate
2. Discussions and conclusions during the PHC EG's planning workshop in Helsinki 1.-3.2. 2005.

Cross-cutting principles

All activities of the group should be implemented in a good and close cooperation with the Partnership Secretariat.

The PHC EG **recognises the following cross cutting issues**, which will be taken into account in all actions, considered or promoted by the Group:

1) The PHC EG will promote improvement of the general awareness concerning the role and significance of Comprehensive Primary Health Care as one cornerstone of functioning health care system.

2) The work of health care and social workers is highly demanding and extremely important for every citizen during some phase of life in all societies. Therefore, the PHC EG will work for development of positive attitudes towards health care and social professionals.

3) The PHC EG will promote raising the general understanding on Northern Dimension, its objectives, actions and the mandates of the working groups.

4) The PHC EG offers expertise as a referee group for new projects in the ND area.

5) Gender questions

6) Environmentally sustainable development in all actions

Special Tasks for the Primary Health Care Expert Group

The Primary Health Care Expert Group suggests that the following tasks will be included in its mandate:

1) **Advocacy and lobbying for Primary Health Care within the framework of ND PHS.** The Group will also promote Public Health, development of Primary Health Care as part of the health service systems and health sector reforms.

   A special task for the EG is to improve the image concerning health care professionals and profession as well as importance of PHC in the Public opinion.

2) **Establishing close connections with other expert groups** and promotion of functioning cooperation with them as one prerequisite for a successful implementation of future tasks. The first priorities are in HIV, Prison and Training groups.

   The PHC EG also recognises the need for collaboration with civil sector tuberculosis authorities and institutions. The Group seeks for collaboration also with other possible groups and authorities as relevant, especially working for healthy life styles, health promotion and prevention of diseases.

3) **Professional advice and support to authorities**: the PHC EG members are high level professionals and representatives of their countries, acquainted with both practical work and the policies behind it.

   Therefore, the Group is ready and willing to provide professional information and advice about the actual situation, tendencies and development needs of the health sector within the ND area, to relevant ministries and embassies. This can include meetings with authorities, visits in participating countries and written information.

4) **Technical referee group** for new project proposals, project identification, planning, implementation and monitoring.

   In this respect, also having good understanding of the health sector situation in the ND area, the PHC EG can identify needs and develop initiatives for new projects, identify actors and new partners and assess relevance and technical quality of plans and proposals in the region. The Group can make recommendations concerning project proposals or implementation and assist in planning as requested.

   In all its work the PHC EG takes into account especially the needs of various vulnerable groups, the threats of communicable diseases and public health views as cross cutting elements.

   The Group is committed to inform and consult the NDPHS Secretariat and other relevant stakeholders about the Group's actions and the development of the sector as necessary.

Attachment 1. Notes on the PHC EG Discussions on February, 1.-3. 2005

Main Beneficiary Group:
Population in the Northern Dimension Area, covering all relevant countries, including Barents region

Potential / possible sub-groups of beneficiaries

- Families
- Care takers
- Mothers
- Children and youth
- Health care professionals
  - Family physicians
  - Social workers
  - Nurses
  - Other health professionals
- State/government authorities
- Health Ministries
- Other ministries
- Governmental institutions
- Prison authorities
- Local authorities
- Professionals in the need for occupational health services
- International and bilateral organizations, including ND and NGOs
- Vulnerable groups
  - People living with HIV/AIDS
  - Homeless
  - Unemployed
  - Uninsured
  - Sex workers
  - Disabled
  - Immigrants, legal and illegal
  - Prisoners
  - Aging population
  - Drug users
  - School drop-outs
  - Chronically ill
  - Mental patients

Actual information from Russian Federation

New laws are prepared and submitted to the Parliament after the changes in 2004:

1. **Medical Care Coverage and packages:** Each territory will decide on different packages, depending on funding
2. **Medical Insurance:** Obligatory insurance system and state revenues will be collected by the Medical Insurance Fund, which will be as part of the Federal Fund, and decide on revenue to be collected from territories according to their wealth. **Contribution of employees:** It will be reduced to 2.6% from 3.6%, which will be supplemented by State revenues.
3. **Changes and Privatization of Medical Facilities:** Facilities can decide to be a non profit, private organizations, to increase efficiency and fund raise.

State Programme on Increasing Effectiveness of the Structure: This includes principles on increasing PHC, decreasing secondary care and treatment; develop specialized high technology facilities,

PHC definition in Russia: physicians, including family physicians, and/or paediatricians, and/or internists, and/or gynaecologists covering a certain population, all other services are accepted as specialized services. Those groups are functioning as gate keepers. Patients can register and have more than one physician.

Fee for services system is introduced back again, at the same time almost no resources nor payments for prevention are available.

GPs or Family Physicians: should receive additional two year training after medical education to receive certificates (there are only approximately 100 FP in RF), they are supposed to be the gate keepers for specialized services. Feldschers will be kept as general helpers to FPs.

Attachment 2. Results of rapid brainstorming for identification of problems and development needs

Estonia

1. Lack of financial resources
2. Not enough support to General Practitioners from government and local authorities
3. Suicide and mental health problems, particularly for children
4. Brain drain (32% have medical school residents in other countries)
5. Poverty
6. Accidents
7. Alcohol and drug abuse
8. Health care of uninsured and homeless people is insufficient
9. Hiv/aids, drug resistant tuberculosis cases
10. Poor health behaviour
11. High cancer incidences
12. Lack of money from insurances

Finland:

1. Poor incentives to work in PHC for health professionals
2. Low motivation of staff
3. Currently not always direct recruitment, but using contractual arrangements for service delivery
4. Public health understanding is missing
5. Growing number of chronic diseases, particularly diabetes
6. Psychological problems of young people
7. Difficult access to primary health care services
8. Physiotherapy for elderly people is insufficient
9. Alcohol abuse
10. Problems in the collaboration between phc and social care
11. Problems between different professional groups

Latvia

1. Communicable diseases, (Hepatitis, MDR Tb and diphtheria)
2. Cancer
3. Alcohol and tobacco
4. Car accidents
5. Insufficient resources
6. Lack of human resources for effective PHC

7. Training for fps are under development
8. Department for Fm is under development
9. Process of changing reimbursement syst.

Lithuania

1. Insufficient financial resources
2. Motivation of family doctors to work in phc is not strong enough
3. Integration of public health into phc (not enough time and lack of knowledge for public health work)
4. Access and long waiting list for specialized care (Family Doctors are gate keepers)
5. Alcohol and drug abuse
6. Ageing population and disabled, long term care for social and health care services
7. Out of pocket payment for drugs
8. Cancers (cervical and breast)
9. Suicides, especially among adults
10. Insufficient education to work on prevention

Norway

1. Different priorities on the political agenda
2. Need for psychiatric training (on the political agenda, funds are excessive than the system could absorb)
3. Ageing population, complex health care problems, multi organ failures, geriatric care, how could phc have more role in care of those groups, coordination with second level institutions
4. Cancers, increasing capacity for diagnosis and treatment
5. Drug abuse, combined with other forms of psychiatric problems
6. Muscular-skeleton problems among middle aged women, stress related (30% of all consultations)
7. Expenditure for health care per citizen, problems with effectiveness and efficiency of the system

Poland:

1. Unstable situation regarding family doctors, no long term contracts, job security
2. Decreasing budget for phc
3. Not clear definition of phc
4. Lack of training of fds
5. Brain drain
6. Quality of training on public health
7. Tuberculosis
8. Access to specialized health services
9. Unemployment
10. Smoking

Russian Federation

1. Resistance to reforms from specialized professional groups and politicians
2. Calculations of financial implications are ongoing / are to be done
3. Law on medical insurance to be implemented (Federal funds and local funds)
4. Share of funding to health care is uncertain
5. Law on change of health care facilities from government to privatisation
6. Currently functions of health facilities are ineffective
7. State programme on improving structural effectiveness: decrease hospital days, privatisation, use of technology
8. Introduction of gate keeper functions
9. Need to widen pilot experiments to implement phc reforms
10. Organisation of phc services is confusing
11. Access to health care services;
12. Quality of health care and social care are major problems
13. There are not enough funds for outpatient clinics,
14. Lack of physicians and nurses to work in phc, lack of motivation and low salary for phc staff
15. Low salaries of general practitioners
16. Insufficient incentives
17. Favourism of in-patient care
18. Too short examination time per patient
19. Inefficient bureaucratic procedures
20. Vulnerable groups; homeless, sex workers, drug users (do not have access to medical care)
21. Communicable diseases
22. Chronic diseases
23. No continuing care
24. Out of pocket payment (50 % of all money is used under table: how to legalise the system?
25. Division to different dispensaries
26. Vertical programmes offering separate services, and not integrated at the phc level
27. Mental health can only be provided by psychiatrists, however, 10% of population have depression
28. Phc physicians are considered as a group delivering low quality services,
29. Prestige of phc is low
30. Weak prevention activities
31. There is lack of training and guidelines for phc
32. No syndromic approach / disease approach
33. Preventive system is destroyed when obligatory system is introduced in 1991, no funds now are available for prevention, fee for services do not include prevention
34. There are training standards and they are implemented, including accreditation of teaching institutes by Ministry of Education

35. No clear coordination / insufficient coordination between health and social care
36. Phc reforms on-going but still on the way
37. Many more common problems could be treated at phc level
38. Problems related to implementation of some practical matters, connected to Ministry of Health
39. Differences in developing Family Medicine / PHC between North West Russia - Central level
40. Resistance by pediatricians (fee for service!)
41. Teenage problems (behaviour, drugs, pregnancies etc) are currently directed to pediatricians
42. Needs for retraining
43. Problems of dissemination of understanding and information from research institutes and between Moscow and territories
44. Narrow approach only to money
45. Decreasing life expectancy

Sweden

1. Number of Family Doctors is not enough (aim is 1 physician/1500 population)
2. Motivation and incentives for PHC staff are not satisfactory
3. Discussion on reorganization of PHC facilities, including private practice
4. Different specialists in PHC facilities,
5. Risk of district nurses moving to local communes in the future, which would leave only doctors in PHC facilities
6. Alcohol abuse (average consumption increased from 9 to 11/person/year), especially among young people
7. Accessibility to facilities (Government decision: should have access to the doctor in 1-3 days in half emergencies, 8 days in primary care, 3 months for specialized services)
8. Public health goals defined by government (11 priorities), how to implement those at the local level
9. Cost of drugs have increased
10. Medicalisation
11. Unnecessary certificates

Tuberculosis

1. How to reach all rights: persons-time-quality-amount: PHC & system development should be priority
2. How to clarify if tuberculosis is a problem
3. Tuberculosis situation may change and have serious long term impacts
4. There is a risk of loosing tuberculosis expertise
5. At the moment tuberculosis knowledge and expertise is in a "wrong place"
6. Risk groups (prisoners, homeless etc) have difficult access to services
7. Tuberculosis case finding and part of treatment could be done in phc
8. Understanding of real risks of tuberculosis threat is insufficient
9. Stigma: phc does not want to take responsibility of tuberculosis management
10. High no of tuberculosis specialists are still opposing changes
11. Coordination between different projects is weak, which creates confusion
12. Too little horizontal collaboration and flows of information

General Findings and Comments by the Group

Primary Health Care System

1. Need to define scope of work and expectations to Family Medicine and promotion of Evidence Based Medicine
2. Effectiveness and efficiency of the phc system needs improvement
3. Access, in terms of long time waiting, or lack of total access, relevant to all countries
4. Compliance and adherence to health care and advise of staff
5. Communicable diseases package (even though rare, they still need priority to sustain the epidemiological situation; case detection, treatment should be as part of the diseases of high priority)
6. Prioritize mothers and children among vulnerable groups
7. Continue public training and public awareness
8. “anti-everything” life style groups
9. Problems related to out of pocket payment and user fees
10. Communication needs more time with patients, as a result of increased public awareness
11. Coordination and information sharing between programmes
12. How much vertical and how much horizontal - new approaches are needed

13. Training of social workers and other health professionals
14. Patient's rights, especially in prisons the right for treatment
15. Need improvement in health and social sectors
16. Policy guidelines for political decision makers to establish an effective phc
17. People living in rural areas are lacking phc and social services
18. Need to train social workers and basic health workers
19. Disabled people don't get services or social support and they don't know their rights
20. Prison staff lacking knowledge
21. No support system for prisoners
22. Relations between penitentiary and civil authorities are weak
23. Cooperation between health and social sectors is weak
24. Insufficient equipment and improper facilities
25. Insufficient information materials for decision makers

Summary:

Health Care Reforms
Every country is in a process of reform. Many countries have similar or comparable health and social sector problems.

PHC
It is often unclear what is meant with PHC.

PHC services: access, quality, what kind of services, role of prevention and public health, effectiveness of care given, management problems, structure of services

Financial policies
Financial policies concerning insurance systems, privatisation, public-private mix, fee for services etc. need further attention.

Human resource policies
Weak human resources and long term planning, training of health care professionals, education policies for PHC and curricula, reorientation and continuous training policies, motivation of personnel, with incentives, training etc. need clarification

Russia is a special and separate case,
Russian health care system is not a system but, rather, a collection of fragmented elements.

- Discrepancy between low infant mortality rate vs. low life expectancy!

Common problems which have relevance in many, if not all countries:

- Diseases: communicable diseases like HIV/AIDS, tuberculosis and sexually transmitted diseases, respiratory diseases, chronic diseases, asthma, cardiovascular diseases etc.
- Alcohol and drug abuse are growing problems.
- Lack of institutions and institutional capacity.
- Differences between central level and periphery.
- Lack of capacity to build phc system in rural areas.
- Social services and social nursing are weak.
- System approach is indispensable but is weak at the moment.
- No missionary approach but functional reorientation needed.
- Need to build or change institutions.
- Need to inform citizens about civil society.
- Need to identify strengths and resources.
- Mother and Child Health ant the needs of vulnerable groups (ageing, mental h, disabled, unemployed, homeless, poor, prisoners etc.) need more attention.
- Institutionalizing of changes, although not easy, has to be more determined, long term and sustainable.