Reorienting Health Systems and Services with Health Promotion Criteria:

*A Critical Component of Health Sector Reforms*

(Original Version)

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1. THE CONTEXT

1.1 INTRODUCTION

The Ottawa Charter for Health Promotion, developed and adopted by the first International Conference on Health Promotion in November 1986, included as one of the five components of health promotion action, the notion of reorienting health services. Since then, much of the literature and debate has remained either at the level of values and principles, or as isolated components of categorical disease prevention and management interventions. Little progress has been attained in defining an explicit, detailed and commonly agreed upon framework for implementing changes in a systematic fashion. Developing such a framework is one of the major challenges for the Fifth International Conference on Health Promotion in Mexico City.

A preliminary disclaimer in relation to this topic concerns what is often pointed out to be the relative importance of reorienting health services vis-a-vis other health promotion strategies. Health services are but one of the multiple determinants of health status, and indeed not even the most important. At the same time, however, health services are a critical area of social policy. Not only does the health sector consume a considerable portion of any given country’s GNP, but also additionally there are grave inequities in the distribution and use of resources within the sector. Additionally, of course, resources are not always efficiently spent and could be subject to considerable gains through resource allocation practices inspired by the reorientation of health services. Most importantly, however, is the idea that reorientation will improve the quality of care and in this regard, the impact of health services in a population’s health.

A combination of elements present in the current international context makes the call for reorientation of health services relevant today. There are enormous pressures on health systems as a result of the aging of populations and the transformation of epidemiological profiles. New technologies are being introduced and health care costs are soaring. Access to information has increased and, as a result, populations are demanding greater citizen participation in health care. These developments, among others, have placed the need for change in health systems at the center of political debates. Increasingly, there is recognition by different stakeholders within countries that a systematic transformation of the model of care is needed.
1.2 BACKGROUND

In the Ottawa Charter for Health Promotion, *reorienting health services* is described as containing the following elements:

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**Ottawa Charter for Health Promotion**

- shared responsibility among individuals, community groups, health professionals, health services institutions and governments to work together towards a health care system which contributes to the pursuit of health;
- a move of the health sector in a health promotion direction, beyond clinical and curative services;
- a need of health services to embrace an expanded mandate which is sensitive and respects cultural needs;
- a stronger attention to health research and professional education and training conducive to changes in the organization of health services, so they refocus on the total need of the individual as a whole person.

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While these elements moved the Ottawa agenda forward, further operationalization is still required in order to be useful in the organization of health systems and in the delivery of health services. The underlying values need to be translated into a comprehensive framework and into a body of knowledge that guides and supports the implementation of change.

International health promotion meetings subsequent to Ottawa concentrated on other aspects of Health Promotion but did not address the subject of reorientation of health services as a central concern in their debates.

One of the few comprehensive proposals for reorienting health services produced since the Ottawa Conference is the report issued by the Canadian Public Health Association, *Focus on Health: Public Health in Health Services Restructuring* (1996). It offers a thorough framework that highlights a number of objectives (See Appendix B). While this is a step forward, there is still a need to organize objectives into categories; strategies and mechanisms for monitoring and evaluating the evolution and impact of the restructuring processes.

Such an operational framework is vital for both the advocacy efforts in favor of the reorientation of health systems and services with health promotion criteria and for the incorporation of these areas of transformation into the country’s health sector reform agenda.
1.3 **The Context of Health Sector Reforms**

In the last two decades, there has been a widespread effort to implement change in the organization and financing of health systems. These changes have been termed *health sector reform processes*. Health sector reforms are by definition enormously diverse and form part of larger processes of change within countries. Surprisingly, however, there has been substantial similarity in the packages of reform measures applied.

In the region of the Americas, an exercise was carried out following the 1994 Summit of the Americas. Member governments of the Pan American Health Organization defined five “Guiding Principles” of health sector reforms, by which they proposed to monitor and evaluate health sector reforms (Figure 1). While many reforms in the region emphasized only one or two of these principles, all agreed that no reform should run contrary to these criteria, and that the “ideal reform” would be one in which all five aspects had improved by the end of the process. Such a consensus building process has been extremely useful, not only in monitoring reforms, but also in the effort to *reorient* health sector reforms.

![Figure 1](image)

The results of this monitoring activity, together with analyses produced by other organizations in other regions of the developing world, allow for a preliminary assessment of the impact of the health sector reform in accordance with the framework presented in Figure 1.
Equity: Only a few health sector reforms seem to be slowly contributing to the reduction of gaps in the coverage of some basic services and programs, although there are difficulties in measuring this dimension of reforms. In most countries, they are not contributing to the reduction of gaps in the distribution of resources.

Effectiveness and quality: Relatively little progress has been attained in improving the global effectiveness of the system, or in improving adherence to normative aspects of quality of care or user satisfaction with quality.

Efficiency: Analysis suggests that there have been greater gains in productivity and development of purchasing practices than in reorienting resource allocation. For example, there have been no major shifts in the channeling of resources to address problems with high externalities, or to increasing the degree of social protection in health.

Sustainability: There is an attempt to adjust expenditures to the revenues of the system, but very few countries are improving medium or long term resource generation for expanding or sustaining the current level of service provision. This situation is aggravated by the high dependency on external financing observed in many countries, and the lack of mechanisms for substituting the flow of resources when they cease.

Social participation: There is some indication that there is greater receptivity by governments as a result of health sector reform agendas. This introduces a greater degree of checks and balances into the system. Whether this proves meaningful in terms of reorienting the course of reforms remains to be seen.

In sum, the driving motivations of reforms have centered so far on economic factors, relegating equity considerations and public health concerns to a secondary level. Quality of care, and more specifically the model of care provided, has been marginal to reform debates in most countries.

It is in this context that the reorientation of health systems and services using health promotion criteria should be framed. An agreed upon framework for advancing change in this direction should be actively promoted in debates concerning the future of health sector reforms around the world. To this end, the following sections elaborate on some of the aspects necessary for advancing an operational framework for reorienting health systems and services.
2. OBJECTIVES AND STRATEGIES FOR THE REORIENTATION OF HEALTH SYSTEMS AND SERVICES

2.1 SUMMARY TABLE OF OBJECTIVES AND STRATEGIES

In the following section, a series of objectives and strategies for the reorientation of health systems and services is described. In order to further the development of an operational framework, objectives and strategies are divided into two levels which reflect complementary, but specific realms of actions:

- **Health Systems Development**, which concerns the institutional set-up of the health sector and the way in which the functions of the health system (steering role of the health authority, financing, insuring, and provision of services) are organized and are being performed.

- **Provision of Health Services**, which involves the design and implementation of health care models, as well as the specific ways in which services are organized and managed to deliver community and clinical interventions as defined in the model.

With regard to the objectives and strategies listed below, a preliminary comment is that most are not exclusive to health promotion values and criteria; they are actions and strategies that have been conceptualized in relation to many health care goals, but which together, potentially have the effect of furthering the reorientation of health systems and services with health promotion criteria.

Secondly, it is important to stress the legitimate differences that arise between countries and within different regions of a given country in regard to the definition of which actions are coordinated by health services and which actions should be executed by other sectors. While there may be advantages of tying as many health promotion actions as possible to health services, such as elevating the status of health promotion in the eyes of the population, it may also have disadvantages, such as over-medicalizing or introducing excessively hierarchical relations in the communication process.
### SUMMARY TABLE

**OBJECTIVES AND STRATEGIES FOR REORIENTING HEALTH SYSTEMS AND SERVICES**

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<tr>
<td>1. Define, implement and evaluate <strong>Essential Public Health Functions</strong> as part of the responsibilities of the steering role of health authorities.</td>
<td>1. Advocate and facilitate dialogue and consensus between stakeholders in order to expand consensus on need for reorientation and to maximize resources for promotion.</td>
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<td>2. Induce financing and resource allocation practices that give priority to the development of public health infrastructure and to the lines of action aimed at reorienting health care delivery with health promotion criteria.</td>
<td>2. Incorporate objectives of reorientation of health systems and services into resource allocation and payment mechanisms, linking payment to health outcomes when possible.</td>
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<td>3. Incorporate the contents of reoriented health care delivery models into the basic portfolio of entitlements of social and private insurance schemes.</td>
<td>3. Develop public health infrastructure and evaluate the performance of essential public health functions.</td>
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<td>4. Change the composition and balance of the type of health care, and incorporate promotion and prevention as an integral part of the health care delivery model.</td>
<td>4. Include health promotion criteria in regulatory mechanisms, such as certification, licensing and accreditation of facilities, provider networks, health professionals and insurance plans.</td>
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<td>5. Incorporate advocacy of health promotion principles in health service management models.</td>
<td>5. Improve responsiveness and technological capacity of health care as a necessary prerequisite for establishing social legitimacy of services from the viewpoint of the population.</td>
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<td>6. Ensure sensitivity to needs and expectations of specific sub-groups in the community, including gender and age differences, as well as religious, ethnic and other cultural determinants.</td>
<td>6. Increase the relative importance of points of entry to the health care system, and establish programs with primary health care providers that assume responsibilities for patients, families and communities and help them navigate their way through the system.</td>
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<td>7. Engage individuals in the process of informed decision making about their own health and that of family members.</td>
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<td>8. Promote consensus among experts on clinical prevention guidelines, eliminating ineffective practices, and train, supervise and evaluate implementation of guidelines.</td>
<td>8. Ensure that organizational conditions facilitate implementation of guidelines, including strategies for modifying provider practices.</td>
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<td>9. Promote consensus among experts on clinical prevention guidelines, eliminating ineffective practices, and train, supervise and evaluate implementation of guidelines.</td>
<td>10. Improve communication between providers and patients, as well as health services and the communities, in order to increase effectiveness and utility of actions.</td>
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<td>10. Strengthen health promotion component in human resources development programs, both in academic institutions and continuous education of health professionals.</td>
<td>11. Create mechanisms that establish formal commitment and co-responsibility between services and individuals and communities, including community feedback mechanisms.</td>
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### 2.2 HEALTH SYSTEMS DEVELOPMENT

**Objective 1:**

Define, implement and evaluate **Essential Public Health Functions** as part of the responsibilities of the steering role of health authorities.

Any major effort to produce change in the health system should ideally strengthen the major public health functions for which health authorities in a given country are responsible. This goes in tandem with the general efforts aimed at redefining the steering role function of the health authorities. In many countries, work is being carried out to make public health functions more
explicit, to develop methodologies and tools for monitoring the performance of such functions, and to use these elements as inputs for improving public health practice and for overhauling public health infrastructure (See Appendix A for list of Essential Public Health Functions as developed by PAHO, CDC and CLAISS in the Americas).

The relationship of essential public health functions to the reorientation of health services with a health promotion approach operates at two levels. First, strengthening the state’s capacity to carry out each of the essential public health functions also furthers the objectives of health promotion. Adequate performance in all areas of public health increases the legitimacy of health authorities as responsible, capable and critical parts of the health system. It also increases the system’s ability to further the health promotion function itself. Lastly, by clearly delineating essential public health functions and measuring their performance, intersectoral alliances, which are critical to health promotion, are enhanced.

**Objective 2:**

Induce financing and resource allocation practices that give priority to the development of public health infrastructure and to the lines of action aimed at reorienting health care delivery with health promotion criteria.

In order that health systems facilitate the implementation of the objectives and strategies of the reorientation of health systems and services with health promotion criteria, mechanisms for financing and allocating resources must induce the process.

**Objective 3:**

Incorporate the contents of reoriented health care delivery models into the basic portfolio of entitlements of social and private insurance schemes.

A critical link between the principles, objectives and strategies of reorientation and its expression in the health care actually delivered is the incorporation of the specific actions in the portfolio of benefits offered, be they public sector, social security, private for-profit or non-profit. To the extent that such actions are not explicitly included in portfolios, it is extremely difficult for health care workers to carry them out on their own.
Strategies for Health Systems Development

Strategy 1:
Advocate and facilitate dialogue and consensus between stakeholders in order to a) expand consensus on need for reorientation and b) maximize resources for health promotion.

Advocacy and social communication are actions that relate to all of the objectives. The inertia of health systems is such that the reorientation of health systems and services is not a development that will take place spontaneously. It is imperative that health authorities and others assume an advocacy role with all those intervening in the process of reorientation, in order to build consensus on the need for change. This involves actions directed towards swaying public opinion, providers, directors, purchasers as well as those affecting financing mechanisms.

Key to the concept of advocacy is the idea of developing shared agendas with long and short-term goals that are openly debated. Within the health system, these agendas should form part of larger health sector reform agendas, as well as the quality management and assurance programs. Definition of agendas also allows different sectors to define complementary activities and in this way maximize the use of limited resources available for health promotion.

Strategy 2:
Incorporate objectives of reorientation of health systems and services into resource allocation and payment mechanisms, linking payment to health outcomes whenever possible

In relation to Objective No. 2 reorienting health systems and services requires the inclusion of health promotion criteria in both the mechanisms for allocating resources either territorially, by program or in the purchasing agreements with health care services, and in mechanisms that define provider payment schemes. To the extent that specific health promotion actions may be identified, and their implementation actually monitored and evaluated, it is possible that management systems can link payment to performance in this arena.

The Managed Care movement has been at the forefront of experimentation in this regard, although within the movement there are radically different interpretations of the concept. The Centers for Disease Control (CDC) of the United States is currently reviewing such experiences in an effort to identify best practices for incorporating the objectives of reorientation of health
systems and services with health promotion criteria into networks of services and insurance plans.

**Strategy 3:**

**Develop public health infrastructure and evaluate the performance of essential public health functions**

In relation to Objective No. 1, defining and measuring the Essential Public Health Functions (EPHFs) should contribute to the institutional development of both the practice of public health and the improvement of public health infrastructure. It allows for a more rational allocation of resources and is an important input into public health education programs. (Specific indicators reflecting required public health capacities are listed in the Appendix)

**Strategy 4:**

**Include health promotion criteria in regulatory mechanisms, such as certification, licensing and accreditation of health facilities, provider networks, health professionals and insurance plans.**

It is important to consider the opportunities that regulatory actions provide, including certification, licensing and accreditation procedures. Such regulation spans health service facilities, networks of services, specific health care professions and insurance plans. Such mechanisms could potentially become a powerful instrument for inducing the reorientation of health services. In the case of professionals, for example, continued education in the area of health promotion might be a requisite. In the case of insurance plans, the inclusion of certain types of services would be required.

### 2.3 Provision of Health Services

In order to change the model of care actually delivered in health services and in communities, there are innumerable organizational conditions that must be addressed. Depending on the type of health system in question, this involves transforming management models at the level of local health authorities, health plans (be they social security, private for profit and non-profit sector) and, lastly, health service facilities themselves.
Objective 4:

Change the composition and balance of the type of health care, and incorporate promotion and prevention as an integral part of the health care delivery model.

A health promotion approach may be desegregated into several objectives at the level of health service delivery. The first, represented in Objective No. 4, reflects a conceptualization of the increased attention being given to health promotion as one component of the spectrum of health care actions which spans from promotion, to protection, to general prevention, to specific prevention, to curative and palliative treatment, and lastly to rehabilitation. In most health services, the weight of actions undertaken by health care service is placed to the right of the spectrum, as illustrated by the curve in Figure 3. The challenge from this perspective is to fill in the gaps (above the curve) in the delivery of care in order to improve health outcomes with appropriate types of care.

Figure 3

Filling the Gaps in the Spectrum of Care

<table>
<thead>
<tr>
<th>Promotion</th>
<th>Primary Prevention</th>
<th>Secondary Prevention</th>
<th>Treatment</th>
<th>Rehabilitation</th>
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A second conceptualization also contained in Objective No.4 is that of mainstreming health promotion throughout the continuum of care. Here, the notion is that health, rather than disease, be the dominant paradigm that inspires the design and implementation of the health care delivery model. This does not imply that specialists should alter their particular areas of focus, but rather that opportunities for health promotion exist throughout the continuum of care.

An excellent example of the opportunities for mainstreaming may be observed in the area of cardiovascular diseases, where faced with scientific evidence and the demands of patients and more broadly public opinion, health prevention and promotion has been integrated into practice. Today, cardiologists have become perhaps the most enthusiastic supporters of health promotion and in this regard serve as a model for other areas of specialization.
Objective 5:

Incorporate advocacy of health promotion principles in health service management models.

Just as advocacy and social communication strategies are required at the system level, so too must health services managers assume responsibility for their function at the mid and micro levels. Such a leadership role involves a proactive stance on the reorganization of health services, as well as in relation to collaborative efforts with the community and other service sectors, such as education. At the network level, it implies re-conceptualizing each health care facility be it private or public, as part of a system, as opposed to viewing each establishment as an independent entity competing for state resources or paying clients.

Objective 6:

Ensure sensitivity to needs and expectations of specific sub-groups in the community, including gender and age differences, as well as religious, ethnic and other cultural determinants.

One of the limits often identified in the predominant model of healthcare is that the focus is on physiological malfunctions without regard to the social and cultural context of illness and health. While this issue lies at the heart of the medical paradigm, and thus is not easily modified, it is important to keep in mind as a long term objective the need to sensitize providers to the multiple interpretations of illness and health that exist in a given group, both in terms of cultural constructs, and in terms of the material and emotional conditions of daily life for certain social groups. Ideally, healthcare workers should not only understand and respect alternative world views and experiences, but also design prevention, treatment and health promotion actions accordingly.

Objective 7:

Engage individuals in the process of informed decision making about their own health and that of family members.

Closely linked to Objective No. 6 is the issue of engaging individuals and communities in decision-making about their own health and illness. Unilateral determination of the problem and its prevention or treatment is also deeply embedded in the culture of modern medicine. Change in this regard involves altering cultural values and of course, the distribution of power not only in individual encounters between doctors and patients but also between communities and health services, and more broadly, between citizens and the authorities responsible for health policy. In some countries headway has been made, particularly as patients gain (or demand) access to
information and become more and more accustomed to using it in their interaction with healthcare providers.

**Strategies for the Provision of Health Services**

The reorientation of health services in order to effectively implement both individual and community-based health promotion requires an expressly defined *model of care* that identifies health promotion as a priority and coordinates the different health actions. This model should envisage the structural support model (organization of the network of care and flow charts within the network), the normative model (guidelines for management of health), as well as the communication model between providers and patients, and health services and communities. The following strategies together seek to construct such a model of care.

**Strategy 5:**

*Improve responsiveness and technological capacity of health care as a necessary prerequisite for establishing social legitimacy of services from the viewpoint of the population.*

A strong health promotion focus in no way alleviates health services’ responsibility to respond to the demands for curative care. Moreover, to the extent that the curative side of care is perceived as adequate, health promotion is also accorded legitimacy. In this regard, all of the strategies detailed below should be compatible with efforts to improve the quality of curative care.

**Strategy 6:**

*Increase the relative importance of the entry points into the healthcare system, by establishing programs with primary healthcare providers that assume responsibilities for patients, families and communities and help them navigate their way through the system.*

Central to reorientation efforts, regardless of the partial responsibilities held by each level of care, is the designation of comprehensive responsibility for individuals in a given network of care to the primary level of care. This facilitates the vision of care as a continuum and accordingly, the implementation of health promotion actions at whichever level may be required. This involves allocating sufficient administrative, technical, and financial power to the primary
level of care to allow it to direct, coordinate, and orient care in the whole system. Higher levels of care become consultants that apply a specific technology in relation to a specific health problem in an individual that has been sent to them by a central responsible entity.

Some of the most successful experiences in integrating services have been based on the family physician model, as observed in the Canadian, the British, and the Cuban health systems. In Brazil, the Family Health Program also uses family physicians. One of the main reasons for the success of this model in delivering more preventive care is that providers perceive their role to be one of prevention as well as treatment. This simple shift in the perception of roles has been shown to be critical in predicting provider behavior.

**CUBA’S FAMILY PHYSICIAN PROGRAM**

The Cuban model implemented in 1984 has as its primary objective improving the quality of care through the distribution of one family physician per 120-140 families. This is intended to facilitate:

- greater knowledge of each patient's circumstances,
- contemplation of social networks and living conditions in the definition of promotion, prevention, treatment and rehabilitation strategies,
- early detection of disease and
- personal and community based health education and promotion activities.

Among the innovative strategies implemented by the Family Doctor Program was the creation of *Grandparents' Circles* in neighborhoods, which include exercise classes, personal development and emotional support, and the *Adolescents' Circles*, which include reproductive health education and support.

While the purpose of the model was not to reduce costs, it appears that over time it is responsible for a sharp reduction in hospitalization rates, as well as improved health outcomes. (UNICEF, PAHO, UNFPA 1996)

**BRAZIL’S FAMILY HEALTH PROGRAM**

In the context of its health sector reform, Brazil in 1995 launched the Family Health Program. The program has been implemented in approximately 40% of the country's municipal territories, with 6,600 health teams currently serving 13% of the total population. The goal for the year 2002 is to have 20 thousand teams in operation, covering 50% of the population.

Each health care team (one family physician, one nurse, two auxiliary nurses, and four to six community health agents) is responsible for a catchment area that includes 600-1000 families. Community health agents existed prior to the Family Health Program and as the program expands it has incorporated these paid employees under the supervision of nurses. Each community health agent is responsible for approximately 150 families.

The health care team serves as the gateway to the health care services for individuals within the defined territory. In addition to direct assistance, the teams carry out a health situation analysis in collaboration with community leaders and organize their service in accordance with the population's specific health profile.

The impact of the program has been documented in relation to a variety of intermediate variables and...
health outcomes, including the following:

- expanded access to services for groups such as women, children, persons with diabetes, hypertension, etc.;
- expanded immunization coverage,
- nutritional supplements to pregnant women,
- increased number of home visits,
- reduction in hospitalization rates,
- reduction in infant mortality,
- increased social participation and control,
- higher population satisfaction with the quality of care
- higher job satisfaction of health care workers.

Strategy 7:

Strengthen the health promotion component in human resources development programs, both in academic institutions and continuous education of health professionals.

One of the critical problems faced by health authorities and health service managers is the lack of personnel trained to respond to the new demands of reoriented health care services. This includes for example, family physicians and nurses to serve in primary health care programs, as well as non-traditional members of the health team, such as counselors, adult education specialists, anthropologists, community health promotion agents, etc. While the correlation of power between different health care professions in each country will determine the conformation of health care teams, a number of countries are facing similar difficulties in the area of human resources.

One of these problems is the lack of financial and other incentives to go into primary health care, an area traditionally seen as less prestigious than specialized fields. Increasingly, professionals are being recruited from other countries to fill gaps in this regard. Placement in rural areas has also deterred professionals from choosing this field. In some countries, salary scales are adjusted in order to provide financial incentives for those willing to work far from cities.

There are also debates about the content of training programs and the certification process. In England, the prestige of General Physicians make it possible in that country to simply add a residency program accredited by the Real College of General Physicians. Other countries have
created a new specialty, using either continuing education programs supported by agencies and foundations, or formal residency programs supervised by universities or national health services.

Contents of these training programs usually include instruction that seeks to build capacity in the following areas:

- resolution of demands for care
- early detection of disease or risk factors
- counseling
- incorporation of appropriate technology
- use of a “family approach” to health
- coordination of groups
- community education/orientation

Continual education has already been mentioned as an important component of regulatory policies (strategy No. 4). It also clearly forms part of service level management strategies (No. 10).

| Strategy 8: | Promote consensus among experts on clinical prevention guidelines, eliminating ineffective practices, and train, supervise and evaluate implementation of guidelines |

Health promotion actions span both individual care (clinical care) and community-based care. As Battista and Fletcher point out, the historical competition between these two types of prevention has had more to do with tensions between advocates of mainstream clinical medicine on the one hand and public health advocates on the other, than operational difficulties inherent to the field (1987). Most definitions of clinical prevention include three levels of actions: counseling, screening, and prophylaxis. In addition, prevention is usually divided into primary and secondary prevention, depending on whether diagnosis has occurred. The range of community-based health promotion actions assumed by health services varies enormously as other sectors also assume responsibility in health promotion. Generally, these health service activities include the coordination of self-help groups in relation to specific health conditions, an advocacy role in the community on health issues, health education campaigns with regard to priority issues, population based screening and prophylaxis, and lastly, some health services may carry out in local public health functions.

Guidelines are important for both types of prevention activities. The lack of consensus between different groups of experts creates confusion and skepticism at the level of health
workers (Bass and Elford in Battista and Lawrence (ed.) 1988). Some countries have created national commissions that include various professional associations that develop guidelines in order to encourage single negotiated sets of guidelines in relation to either specific diseases, health conditions, or risk factors. Other countries, such as Canada, have concentrated on guidelines for wellness exams by age group and sex.

**US TASK FORCE ON COMMUNITY PREVENTIVE SERVICES**

In 1999, the Center for Disease Control (CDC) of the United States established a Task Force on Community Preventive Services with the mandate to systematically review the evidence on the cost effectiveness of different types of interventions, including both individual and community-based care, in the following areas:

- diabetes
- alcohol misuse
- tobacco cessation
- motor vehicle accidents
- mental health
- physical activity
- sexual behavior
- nutrition
- cancer
- violence

**CANADIAN HEALTH PROTECTION PACKAGE APPROACH**

Canada has adopted a Periodic Health Exam (PHE) which defines a set of primary and secondary prevention procedures based on the specific needs by sex and age groups. It emphasizes only those procedures for which there is some evidence of efficacy and effectiveness. It differs from a complete work-up for diagnostic evaluation in that it is given to ostensibly healthy people. By identifying hidden early disease, an unhealthy state, or a risk factor, the PHE can, in theory, facilitate timely intervention.” (Battista and Flecher 1987)

In order to prioritize preventive procedures that are most urgently required, the Canadian PHE Task Force used the following criteria:

- Current burden of mortality and morbidity attributable to it;
- When applicable, the performance characteristics (sensitivity and specificity) and related features (safety, simplicity, cost, acceptability, and psychological labeling effects) of early detection procedures;
- The effectiveness of primary and secondary preventive interventions.
Clearly, the management and organization of health services is key to enabling or inhibiting changes at the level of health care workers practices. There is a range of basic types of options that managers and policy-makers can consider in defining their own strategies. They include establishing goals in a participatory manner, assuring that clinical guidelines are available and adapted to local needs, providing feedback on performance, practical aids to remind health workers of actions required, financial incentives, non-financial incentives, motivating patients to demand more preventive care, and staff development.

A large body of literature suggests that preventive care will not be delivered so long as it is not an organizational priority (Belcher & Inui 1988). Each health service must establish goals with regard to health promotion that are agreed upon in a participatory and explicit manner by both administrative and technical personnel. Without the participation and commitment of all those involved in the health care delivery process, reorienting services is unlikely to succeed. (Belcher, Berg & Inui 1988; Grindle, MS (1997))

Even once goals have been set and guidelines are available, obtaining adherence to guidelines requires a continuous process of support, supervision and evaluation of clinical practices. This is a function that requires the supervision of experts and thus is usually carried out at a mid-management level.

One of the most effective supervision strategies is feedback. Feedback can be provided either to individual providers or to groups through the use of aggregated charts. Research, however, indicates that it is most effective when done on an individual basis and in a positive, non-punitive setting. (Belchner, Berg & Inui, 1988).

Strategies to remind providers of guidelines include the use of reminder cards in the providers’ office and visual messages in the form of posters on the walls, Both have been shown to be useful in increase performance standards. In addition, flow sheets and computer aids linked to the clinical history records have been used to improve provider’s compliance with preventive norms (Belchner, Berg & Inui, 1988).
The systems of incentives for changing health professional’s practice are comprised of both financial and non-financial components. These incentives include *payment mechanisms* that prioritize promotion and prevention actions at least in three ways:

- Payment by catchment area to encourage the maintenance of healthy population (per capita and similar systems).
- Fee for services in a redefined list of benefits, including such acts as screening, counseling, and health education.
- Bonuses over and beyond basic wages when goals are achieved (for example, % of people or of schools registered in given educational program, diagnosis of risk factors carried out, etc.).

Such incentives can be delivered directly to the individual providers or can be delivered to the responsible institution. This second modality can fail if the institution does not have the legal and administrative flexibility to transfer incentives to the individual providers, a situation that is frequent in public services.

Non-financial incentives include aspects of *labor satisfaction, adequate environment, possibility of career advancement, perception of importance of the performed function, systems of support in the clinical and administrative local management, real response capacity, validation in the presence of the user, etc.*

The *organization of time* is also central issue for management. Most ambulatory health services in the developing world function on a first-come-first-serve basis. Waiting lines are long and time allocated to the medical visit itself is sometimes only two to three minutes. As such, it is not surprising that health care workers view the demand for curative care as competing with, and in some cases actually eliminating the possibility of health promotion actions in the consultation. Increasingly, however, health services are finding ways to schedule visits in advance, which not only saves the patients’ time but also tends to promote more rational utilization patterns. Even when the demand for care concerns acute conditions, there is usually time in the medical visit to ask a few key questions and to motivate patients to return for a preventive visit.
Some health services have found it useful to group patients with similar health needs and to organize periodic meetings in which health care professionals can provide information and counseling. This is often used in the field of family planning, for example, where the amount of information that needs to be communicated is substantial. In the area of chronic illnesses such as diabetes, health education and self-help groups are also increasingly used.

A critical component of non-financial incentives is staff development. This not only serves the purpose of increasing the knowledge base of providers, but also sends the message to providers that they are valued by the system. Participatory methods of staff development are particularly effective.

A final element to be considered in the realm of management strategies is the motivation of patients as an indirect way of motivating providers. In a review of literature on provider practices, Belcher, Berg and Inuin reported that Canadian patients who were trained in the waiting room to ask questions raised more issues during their next visit than did untrained patients (1988).

Posters, educational handouts, waiting room videos are among the tools that have been used both to reinforce the concept of patient’s rights to receive information and participate in decisions concerning their health, and to provide specific health information.

Another tool developed and applied in an effort to motivate greater patient participation in medical visits is the use of abbreviated clinical records that remain in the hands of patients. Two studies in North America indicated that approximately one third of patients carrying such mini-records did actually remind their physicians to perform a preventive actions indicated in the booklet (Belcher, Berg and Inuin 1988).

Lastly, of course, health prevention and promotion activities outside the health services may also have an impact on patient behavior in the context of the interaction with the health care providers.

<table>
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<th>Strategy 10:</th>
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<td>Improve communication between providers and patients, as well as health services and the communities, in order to increase effectiveness of actions</td>
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Having defined what is to be done, and having ensured that working conditions facilitate such actions, a final dimension of change that is necessary concerns communication styles.
Communication includes the issue of respect for patients as well as the development of partnerships that involve shared decision-making between patients and providers and communities and health services.

It is important to stress that the face to face interaction between providers and users is influenced by not only personal attitudes, but of deeply rooted social values ascribed to medical practice. In this regard, communication is guided by inter-subjective ideas about how doctors, nurses, administrative assistants and specific groups of patients should act in the context of a given culture and a given moment of history.

In the case of health care providers, that context is in part determined by years of formal medical education in which the “problem” to be addressed are physical malfunctions. Such a paradigm has been described as the fix it culture. For the most part, providers are trained to see themselves as the principal agent of change in the health status of individuals and as the sole source of legitimate knowledge on health. Patients’ ideas about their own health are reduced to the category of “beliefs” and the numerous social and cultural factors that condition patient’s health practices are largely ignored.

One of the problems with the communication styles inherent in this model is that while it is undoubtedly effective when it comes to complex medical interventions such as surgery, for interventions in the realm of disease prevention and health promotion it is highly ineffective. Patients in the context of complex social conditions and subjective emotions, make their own choices about whether to modify their health behavior; physicians, at best, can simply help patients to make informed decisions.

The objective in reoriented health services, then, should be to develop new communication styles that are based on bilateral, as opposed to unilateral negotiations. Key to this is that providers must view talk as an important part of a medical consultation. They need to go beyond providing information, and to learn to listen, to respect alternative worldviews, and to empower patients by encouraging their independence in regard to decision-making in health and health care.

One of the ironies of the dominant model of communication in the context of health promotion is that it is not only ineffective in producing the desired change in patient’s behavior, but it is also detrimental to health workers themselves. When patients do not modify their
practices in the manner in which they have been instructed, health workers tend to see patients as uncooperative and grow frustrated with their work. This in turn, generates a vicious circle, in which provider/patient relationships deteriorate and patients seek care elsewhere. Continuity of care is interrupted as patients move to another provider in search of a more satisfying relationship.

Changing communication styles is a complex challenge for which there are no easy solutions. Nevertheless, there have been experiences worth noting. These initiatives have as a common attribute a non-confrontational approach that emphasizes health care workers’ participation in the definition of the direction and pace of changes. The basic premise of such efforts is that in order to increase providers’ awareness and sensitivity to the users’ world and perceived health needs, providers’ own needs must be taken into account.

Without doubt, mental health care workers have been at the forefront of change in this regard, having rarely deceived themselves into thinking that they could cure without the active participation of their patients. Alternative health services set up by the women’s movement in many countries have also been on the frontlines of re-defining the model of care. In this case, strategies center on establishing a bond of gender solidarity, which override traditional doctor/patient relations. Empowerment through peer support is also a critical component of feminist health promotion initiatives. Lastly, in the chronic disease prevention and management, particularly in the area of diabetes, health education strategies are increasingly based on a patient-centeredness, leaving behind the more traditional education for “adherence” approach. Anderson and Walker in the United States, for example, have developed modules to teach health care providers skills for empowering patients, tested and found them to be highly effective in producing change in provider communication styles (1991;1998).

More generally, there are those who believe that the principals of Total Quality Management (TQM) are in and of themselves revolutionary to the medical culture, in so far as they stress the need to satisfy internal and external clients. (Nogueira, R. P. 1993). While it is true that emphasis on patient’s satisfaction is a new and important concept, experience has shown that, for the most part, TQM tools have been most useful in increasing productivity and the efficiency of services.

An interesting, albeit modest attempt to introduce change in health workers’ attitudes is also represented in the methodology “Health Workers for Change.” The initiative, sponsored by
WHO in Africa and PAHO in Latin America, includes a set of eight workshops that seek to sensitize providers to the communities needs, in particular those that are specific to women.

In regard to community based communication, many of the same problems that exist in face to face communications between providers and patients also exist when health care workers attend groups or go into the community to provide health education. Understanding and respecting the cultural context as well as the perceived information needs of communities is a critical first step that should be taken before community based health promotion is attempted. Lack of information is but one of the many barriers to behavior change. This has been clearly observed in the area of family planning in many developing countries where despite major governmental programs, such factors as resistance by male partners accounts for low utilization rates. Thus, explanatory models of health and disease held by communities, as well as the power relations within families and within communities need to be taken into account.

### Strategy 11:
Create mechanisms that establish formal commitment and co-responsibility between services and individuals and communities, including community feedback mechanisms.

While social participation has for some time been an enunciated objective of health sector reforms, in fact, communities rarely have a voice in defining the model of care they receive. Community health councils have been created in some countries, with varied degrees of social control actually exercised. In regard to detailed feedback on the quality of care, satisfaction questionnaires are often used despite severe shortcomings. Be it out of politeness or fear of reprisals, most questionnaires result in satisfaction rates that are between 70-85%, with little variation between health services. Additionally, it is well known that closed-ended questionnaires restrict the ability of respondents to express themselves using their own conceptual categories and relating their own experiences. Such mechanisms as listening posts, complaint boxes, or telephone hotlines, where individuals can freely express themselves have been seen to be more useful to the planning process in health services.

### 3. TOWARDS A SECOND WAVE OF HEALTH SECTOR REFORMS

As discussed above, health sector reform processes have predominantly concentrated on financial, structural and organizational changes in health systems and on adjustments to the organization and management of the delivery of personal health care. Issues related to reducing
inequities in health and health care, increasing the effectiveness of health interventions, promoting quality of care and improving public health practice have received much less attention.

These reforms are happening at a time in which the problem of economic, social, and cultural exclusion is increasingly serious. Existing social protection in health, through the channels both of welfare and social security are inadequate to cope with the new problems emerging. Thus, the central challenge facing countries is how to provide citizens, regardless of their ability to pay, with universal basic social protection in health which would help reduce the inequalities of access to quality and effective health services.

Innovation in the extension of social protection in health, however, is by itself insufficient. It must go hand in hand with the reorientation of health systems and services with health promotion criteria. Not only do the poor tend to receive services of lesser quality, but they are also precisely the group that most need preventive and health promotion services. Thus, without a transformation of the model of care provided, serious inequities will continue to exist in the quality of health care services.

As we have argued in the previous section, the reorientation of health systems and services is also linked to the capacity of health authorities to carry out Essential Public Health Functions. Reorientation is facilitated by a strong and well delineated steering role of the health authorities, based on the functions of public health.

In conclusion, this particular historical juncture in health sector reforms may provide an important window of opportunity for health promotion initiatives. In so far as current reforms have neglected public health as a social responsibility, the second wave of reforms will have to include new objectives. We would anticipate that three key issues will be on the agenda: 1) the importance of strengthening the steering role of health authorities, 2) strategies for extending social protection in health and, 3) strategies for reorienting health systems and services with health promotion criteria.

The challenge that lies ahead, then, is both to future operationalize such strategies and to build consensus on the importance of their inclusion in the next generation of health sector reforms.
# Bibliography


Canadian Public Health Association (1996) *Focus on Health: Public Health in Health Services Restructuring*.


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The following twelve *Essential Public Health Functions* (EPHFs) have been identified as being critical for public health practice in the Americas. The twelve functions are the basis of the performance measurement instrument to measure public health practice which has been developed by PAHO in collaboration with the Centers for Disease Control and Prevention (CDC) and the Centro Latinoamericano de Investigación en Sistemas de Salud (CLAISS).

**Essential Function Nº 1: Health Situation Monitoring and Analysis**

- Up-to-date evaluation of the country’s health situation and trends and their determinants, with special emphasis on identifying inequities in risks, threats and access to services.
- Identification of the population’s health needs, including assessment of health risks and the demand for health services.
- Management of vital statistics and the specific situation of groups of special interest or at greater risk.
- Assessment of the performance of the health services.
- Identification of nonsectoral resources that support health promotion and improvements in the quality of life.
- Development of technology, experience, and methodologies for management, analysis, and communication of information to those responsible for public health (including actors from outside the sector, health providers and citizens).
- Definition and development of agencies to evaluate and correctly analyze the quality of collected data.

**Essential Function Nº 2: Epidemiological Surveillance/Disease Prevention and Control**

- The capacity to conduct research and surveillance on epidemic outbreaks and patterns of communicable and noncommunicable diseases, accidents and exposure to toxic substances or environmental agents harmful to health.
- A public health services infrastructure designed to conduct population screenings, case-finding and epidemiological research in general.
- Public health laboratories capable of conducting rapid screening and processing a high volume of tests needed to identify and control emerging threats to health.
- The development of active programs for epidemiological surveillance and control of infectious diseases.
- The capacity to link with international networks that allow for better management of relevant health problems.
Preparedness of the NHA to initiate a rapid response to control health problems or specific risks

**Essential Function Nº 3: Health Promotion**

- Community health promotion actions and development of programs to reduce risks and threats to health with active citizen participation.
- An intersectoral approach to making promotional actions more effective, especially those involved with the formal education of young people and children.
- Health promotion activities aimed at empowering citizens to change their own lifestyles, play an active role in changing community habits and demand that the responsible authorities improve environmental conditions to facilitate the development of a “culture of health.”
- The implementation of activities aimed at making citizens aware of their right to health.
- The active participation of health services personnel in the development of educational programs in schools, churches, workplaces, and any other relevant social organization where information on health can be delivered.

**Essential Function Nº 4: Social Participation and Empowerment**

- Facilitate the participation of the organized community and civil society groups in prevention, diagnosis, treatment, and rehabilitation programs.
- Strengthen the building of intersectoral partnerships with civil society that make it possible to use all the entire human capital and material resources available to improve the health status of the population and promote environments that foster healthy lives.
- Incorporate the support of technology and experience in the development of networks and partnerships with organized society in health promotion.
- Identify community resources that collaborate in promotional actions and in improving the quality of life, strengthening their power and capacity to influence the decisions that affect their health and their access to adequate public health services.
- Report to and engage in advocacy with government authorities with regard to health priorities, particular with respect to priorities that depend on improvements in other aspects of the standard of living.

**Essential Function Nº 5: Development of Policies and Planning in Public Health and the Steering Role of the NHA**

- The development of political decisions in public health through a participatory process at all levels that is consistent with the political and economic context in which the decisions develop.
- Strategic planning on a national scale and support for planning at the subnational levels.
- Definition and refinement of public health objectives, which should be measurable, as a part of the strategies for ongoing quality improvement.
Evaluation of the healthcare system to define a national policy that protects health services delivery with a population-based approach

Development of codes, regulations, and laws to guide public health practices.

Definition of national public health objectives to support the steering role of the Ministry of Health or its equivalent in defining the objectives and priorities for the health system as a whole.

**Essential Function 6: Regulation and Enforcement in Public Health**

- Development and enforcement of sanitary codes and/or standards to control health risks related to the quality of the environment; the accreditation and quality control of medical services; the certification of the quality of new drugs and biological substances for medical use, equipment, or other technologies; and any other activity that involves compliance with laws and regulations directed toward protecting public health.
- The creation of new laws and regulations directed toward improving public health and promoting a healthy environment.
- Consumer protection as it relates to health services.
- Carrying out all of these regulatory activities in a manner that is timely, appropriate, consistent and complete.

**Essential Function 7: Evaluation and Promotion of Equitable Access to Necessary Health Services**

- Supports equitable access to health care includes the evaluation and promotion of effective access by all citizens to the health services they need.
- Refers to the manner in which the NHA evaluates and promotes access to necessary health services through public and/or private providers, adopting a multisectoral approach that facilitates working with other agencies and institutions to resolve inequities in the use of services.
- Although the evaluation is of both personal health care and public health interventions, promotion primarily directed to public health actions of a collective nature, particularly those directed to overcoming barriers to access by individuals and communities.
- Facilitates the linkage of vulnerable groups to health services, although it does not include financing for this care, and to health education, health promotion, and disease prevention.
- Works in close cooperation with governmental and nongovernmental agencies.

**Essential Function 8: Human Resource Development and Training in Public Health**

- The education, training, and evaluation of the public health work force to identify the needs for public health services and health care, efficiently address priority public health problems, and adequately evaluate public health actions.
The definition of licensure requirements for health professionals in general and the adoption of ongoing programs to improve the quality of public health services.

The formation of partnerships with programs for professional development that ensure that all students have relevant public health experience as well as continuing education in public health management and leadership development.

The development of skills for interdisciplinary work in public health.

**Essential Function 9: Ensuring the Quality of Personal and Population-based Health Services**

- Promoting permanent systems for quality assurance and for monitoring the results of evaluations made through those systems.
- Facilitating the development of the basic standards required for a quality assurance system and supervising the compliance of service providers with this obligation.
- A health technology assessment system that supports the decision-making process for the entire health system.
- Using scientific methodologies to evaluate health interventions of varying degrees of complexity.
- Using this system to improve the quality of the direct provision of health services.

**Essential Function 10: Research, Development, and Implementation of Innovative Public Health Solutions**

- The continuum of innovation, which ranges from the efforts of applied research to promote changes in public health practices to formal scientific research.
- The development of the health authority's own research capacity at its different levels.
- The establishment of partnerships with research centers and academic institutions to conduct timely studies that support decision-making of the NHA at all its levels and in as broad a sphere of action as possible.

**Essential Function 11: Management Capacity to Organize Health Systems and Services in Public Health**

- The management of public health in terms of the process of building, implementing, and evaluating organized initiatives designed to address population based health problems.
- The development of competencies in evidence-based decision-making that incorporates planning and evaluation, resource management, leadership capacity, and effective communication.
- Quality performance of the public health system resulting from successful management that can be demonstrated to providers and users of services.
**Essential Function 12: Reducing the Impact of Emergencies and Disasters on Health**

- The planning and implementation of prevention, mitigation, preparedness, and early response and rehabilitation activities related to public health.
- A focus that encompasses the origins and threats of any and all possible emergencies or disasters that can affect a country.
- Participation of the entire health system and the broadest possible intersectoral cooperation.
APPENDIX B:

Canadian Public Health Association’s Major Recommendations:  
*Focus on Health: Public Health in Health Services Restructuring* (1996)

A) Collaboration between professionals and communities to identify, develop and deliver a broad range of needed services which recognize all of the determinants of health to improve the health of individuals and communities;

B) collaboration between health and other sectors to develop services addressing the broad determinants of health and to maintain healthy public policies initiatives;

C) reflect an integrated continuum of services encompassing health promotion, disease prevention and health protection; wellness and health maintenance; community based care; facility-based care; and specialized institutional care;

D) support the development of strong links within the health system, within and across disciplines and across geographic boundaries, to provide peer support and share information, skills and experiences;

E) ensure an appropriate realignment of professional perspectives, skills and knowledge to reflect changes in the system;

F) enable individuals to make healthy choices by providing needed information and facilitating skill development;

G) be responsive to and support advocacy efforts aimed at improving the effectiveness of the health system and the health of populations;

H) have public funds available to ensure equitable access to needed services by all citizens;

I) take direction from legislation mandating appropriate, core health services and develop population-based funding mechanisms which provide flexibility in meeting the needs of different populations;

J) shift a portion of available resources within the health system from facility based care to community-based promotion and prevention strategies;

K) build governance and management systems that involve and are representative of the individuals and communities they serve;

L) maximize the effectiveness of the health system through evidence-based practice, needs assessments and evaluations; and

M) provide health and wellness outcome indicators and other information on health impacts and health status to the public providers and decision makers for use in the planning, delivery and evaluation of health services and systems.