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WHO Regional Office for Europe Centre for Primary Health Care

This information document contains the technical profile for the new WHO Regional Office for Europe Centre for Primary Health Care, approved by the Twentieth Standing Committee of the Regional Committee for Europe at its third session in March 2013. It should be read in conjunction with working document EUR/RC63/22, which presents the business case for the Centre.

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WHO Regional Office for Europe Centre for Primary Health Care

Background

1. In its Decision EUR/RC62(2)[1] on strengthening the role of the Regional Office's geographically dispersed offices (GDOs), the WHO Regional Committee for Europe, at its sixty-second session (RC62), requested the Secretariat to develop a business model for a potential new GDO on Primary Health Care (PHC), with the full involvement of the Standing Committee of the Regional Committee (SCRC). The SCRC recommended sounding out all Member States for expressions of interest in the two strategic priority areas identified by RC62. This document addresses the Regional Committee's request with regard to the proposal to establish a WHO Centre for Primary Health Care. More specifically, it includes the first draft of a technical profile, describing the services that such a centre would deliver. It is primarily intended to help Member States decide whether they might wish to express an interest in hosting such a centre. In order to help Member States with this decision, this paper also provides, in Annex 1, a short summary of the general principles and prerequisites for establishing GDOs, specifying the conditions that the candidate host countries will need to meet, as well as clarifying the roles and responsibilities of the Regional Office in Copenhagen (which will be setting policy and directing and driving the GDO: item 2 of annex 1) vis-à-vis those of the GDO (which will be responsible for specific technical deliverables: item 3 of annex 1). These principles and prerequisites have been taken from the document on strengthening the role of the Regional Office's geographically dispersed offices, discussed at RC62 (EURO/RC62/11) and its accompanying Decision (EUR/RC62(2)). In response to a request made by the SCRC, the proposed areas of work for the Primary Health Care Centre have been aligned with those of the GDO on noncommunicable diseases (NCDs), in order to synergize their activities. This has been done in line with the Regional Office's programme on health services strengthening for NCD prevention and control.

Situation analysis

2. In May 1977, WHO Member States decided that the main social target of governments and WHO in the coming decades should be "the attainment by all the people of the world by the year 2000 of a level of health which would permit them to lead a socially and economically productive life". This started the Health for All (HFA) movement both globally and in Europe, and it was followed in 1978 by the adoption of the Declaration of Alma-Ata, which presented

[1] Referring to EUR/RC62/11 and EUR/RC62/Conf.Doc./5

primary health care as a set of guiding values for health development and the achievement of HFA. The Declaration of Alma-Ata sets out principles for the organization of health services, and describes a range of approaches for addressing priority health needs and the fundamental determinants of health. The Declaration put PHC on the European health policy agenda and was central to the HFA policy and its 38 targets, as adopted in 1984 and subsequently updated. The key values enshrined in the Declaration are: equal access to health and an end to exclusion; health services that are centred around people's needs and expectations; health security for the communities in which people live; a more holistic approach to health, taking into consideration the significant impact of other sectors on peoples' health; and a health systems approach in which PHC would play an integral and central role. In 2008, the World Health Report: Primary health care: Now more than ever, gave new impetus to the PHC approach, focusing on universal coverage, universal access, stewardship and integration with public health.

3. Although widely supported, the visions enshrined in the Declaration of Alma-Ata, HFA and the World Health Report, Primary Health Care: Now more than ever, have not always easily translated into an effective transition to health systems based on PHC. Since 2008, country studies have been conducted, in order to map the PHC situation in individual countries and make recommendations on how to improve it. More emphasis on innovative PHC is required, however, based on exchanges of country experiences and research, in order to deliver evidence-based products, which are tangible and implementable, and which will contribute to improving the health care situation throughout the WHO European Region. Member States have gradually started to realize that, as well as being cost-effective, PHC is the key to a sustainable health system. In a number of countries, economic crisis has added impetus to the drive towards people-centred PHC-based health systems as a sound financial approach. Member States are aware that PHC reduces or removes the need for hospitalization and increases patient satisfaction, and it facilitates the implementation of the essential public health operations (EPHOs) set out in the European Action Plan for Strengthening Public Health Capacities and Services, particularly those related to service delivery. PHC also facilitates public health activities (health promotion, prevention and protection) and contributes to the reduction of NCD prevalence.

4. The Regional meeting on strengthening the contribution of primary care in prevention and control of NCDs, jointly organized by the Regional Office and the WHO collaborating centre the Netherlands Institute for Health Services Research (NIVEL) on 25–26 January 2012, included discussions on a draft tool entitled "PHC evaluation for better NCD prevention and control". During the meeting, participants from all 53 Member States in the European Region discussed and agreed on the most common perceived barriers and enablers for effective PHC development, which are outlined in Table 1 below.

Table1. Perceived barriers to and enablers for effective PHC

Barriers	Enablers
Lack of transition towards a holistic and balanced approach between curative hospital-based and preventive community-based model	Recognition that health sector leadership depends on many "external" factors
Fragmentation of health systems	Sustained political commitment to ensure that health funding meets population needs
Lack of political commitment	System-wide approaches
Inadequate use of local data	Greater emphasis on health promotion and prevention as part of a comprehensive service delivery model
Suboptimal intersectoral collaboration	A participatory approach and support for self-management
Lack of investment in human resources, including training, working environment, incentives (particular reference was made in that regard to nurses)	Universal coverage to remove financial barriers

5. The recently approved European policy framework for health and well-being, Health 2020, highlights new challenges and in so-doing reinforces the need for Member States to strengthen health systems by basing them on people-centred PHC, while maintaining the values and principles of HFA and the Tallinn Charter: Health Systems for Health and Wealth, adopted in 2008. Importantly, Health 2020 calls for a broad social movement to put the commitments to PHC, enshrined in the Declaration of Alma-Ata, into practice.

Rationale behind establishing a GDO on PHC

6. Under the WHO reform process, one of the three priorities for health system strengthening (Category 4 of the categories for priority setting and programmes in WHO) is integrated health service delivery with PHC at its centre. PHC is also at the centre of the implementation of the WHO European Action Plan to Strengthen Public Health Capacities and Services, adopted at RC62, as well as the Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016, Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015, and the European action plan for HIV/AIDS 2012–2015, all adopted at RC61. Many public health and curative services are provided through PHC, not least screening and follow-up for communicable diseases and NCDs.

7. The establishment of a GDO on PHC would provide the additional technical capacity required for the WHO Regional Office for Europe to meet these increased demands in line with the Declaration of Alma-Ata Declaration, the World Health Report 2008 and Health 2020. It would enable implementation of the Regional Committee's resolutions to be accelerated, and would help countries respond to contemporary realities, by transforming their health systems to meet the needs of an ageing population, elevated public expectations, needs with respect to developing human expertise and skills as well as sophisticated technologies, and meet challenges posed by population migration, unregulated pharmaceuticals markets and financial constraints.

8. There is an increasing demand for technical leadership and support for countries that are reforming their PHC and transforming their health services. The table below shows what Member States have requested from the WHO Regional Office in terms of technical support on PHC for the biennium 2012–2013.

Table 2

PHC country action requested	Countries
Conduct a comparative study on the PHC evaluation tool	Andorra, Belarus, Kazakhstan, Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Tajikistan, Turkey, Ukraine, Uzbekistan
Develop evidence-based, cost-effective interventions in PHC to shorten hospitalization or avoid it altogether	The Netherlands
Develop background research on innovative PHC	Kazakhstan (2013 marks the 35th anniversary of the International Conference on Primary Health Care in Alma-Ata)
Develop options for preventive interventions on cardiovascular diseases and diabetes through PHC	WHO European Region, all 53 Member States

The GDO on PHC as an operational unit of the Regional Office's Health Services Delivery Programme

9. The proposed PHC GDO will be embedded into the Health Services Delivery Programme (HSD) of the Division of Health Systems and Public Health (DSP), with close links to the other technical programmes in DSP and across Divisions (particularly NCD) through the new operational approach to health system strengthening: innovative people-centred health systems for better health outcomes. In the context of Health 2020, HSD aims to support Member States in designing, establishing and promoting effective, efficient and sustainable health service delivery, which is safe and of good quality, with a particular focus on the integration and coordination of care and hospital care throughout the life-course and systematizing regional experience and evidence to facilitate knowledge transfer among Member States.

10. HSD counts on a highly qualified and specialized team including a health services organization and management professional (team leader), a PHC expert seconded by the Government of the Netherlands, professionals in the field of quality performance assessment including patient safety and a development expert, supported by one administrative staff member in the Regional Head Office in Copenhagen.

11. The PHC GDO will be an operational unit of HSD and will operate under the policy, technical guidance and direct supervision of the Director of DSP at the Regional Head Office in Copenhagen, in coordination with the HSD Programme Manager. It will, at the same time, serve as a knowledge and learning hub attracting and disseminating good practice, best buys and actionable policy options for countries to inform their frontline managers about renewed and innovative PHC. Its location in DSP will also enable close cooperation and synergies with the Barcelona GDO on Health Systems Strengthening, with a particular focus on health financing.

12. The Regional Head Office in Copenhagen will perform core functions with regard to setting norms and standards, developing guidelines and formulating policy, as it does for all GDOs.

Added value that the GDO on PHC can give to the Health Services Delivery Programme

13. Despite having this staff of qualified professionals, HSD still faces important challenges that can only be met by further mobilizing resources and support. These challenges include: increasing demand for support for implementing PHC and transforming health systems; conceptual pitfalls and lack of evidence on what works and does not with regard to scaling up PHC interventions; a lack of contextualization and hands-on experience of managing change at primary care level; a need to develop critical mass and expertise; and the fact that financial and technical resources devoted to PHC remain limited and have been reduced substantially as a whole over recent years, particularly at country level (decreasing number of technical staff based in WHO country offices).

14. It is expected that the proposed GDO on PHC will significantly increase DSP's resources, enabling the increasing requests from Member States to be met in a timely and adequate manner. The GDO will contribute, in particular, to developing a critical mass of qualified and skilled professionals in the WHO European Region, and it will equip the Regional Office with innovative tools for transforming health systems and aligning them with the values and objectives of Health 2020.

Profile of the GDO on PHC

Objectives

15. As an operational unit of DSP and in line with Health 2020, the GDO on PHC is expected to:

- contribute to and support the Regional Office's efforts to transform health systems towards people-centred, PHC-based health service delivery, in order to respond appropriately, effectively and innovatively to the burden of NCDs, communicable diseases, ageing and co-morbidities;
- actively support European Member States in their efforts to implement commitments undertaken at Regional and global level, in the field of PHC-based health service delivery, in an equitable, responsive, effective and efficient manner; and
- provide high quality operational and innovative knowledge and evidence on people-centred health care services, the coordination, integration and continuity of care, the revised role of hospitals, the coordination, organization and management of health care providers, patient and disease management throughout the life-course, taking account of chronicity and including palliative care, and other relevant challenges to Member States' efforts to scale up universal health coverage.

Priority areas of work

16. The workplan for the GDO on PHC will be an integral part of DSP's overall workplan. It will be in line with and will support the implementation of Health 2020, as well as contributing to the achievement of universal health coverage (Category 4 of WHO Programme of Work 2014–19). It is envisaged that the workplan for the PHC GDO will be centred on the four axes described below.

Generating and synthesizing concepts and knowledge

17. This aims to innovate, synthesize existing knowledge and develop analytical frameworks for PHC-based health services delivery, including coordination and management of providers and universal health coverage. It will involve fine-tuning the conceptual framework and tools for assessing PHC-based health service delivery in connection with long-term and social care, and identifying and recording Member States' good practices with regard to strengthening PHC-based health service delivery, ensuring coordination and management of providers, and pursuing universal health coverage.

Providing technical assistance to countries for reforming and innovating PHC and health system delivery

18. This includes country reviews and assessments and ad hoc technical support for:

- efforts to reform PHC and health services delivery and shift their focus towards universal health coverage, life-course and people-centred health systems; and

- measures to improve the organization and management of health care providers in order to ensure continuity and coordination of care throughout life-course.

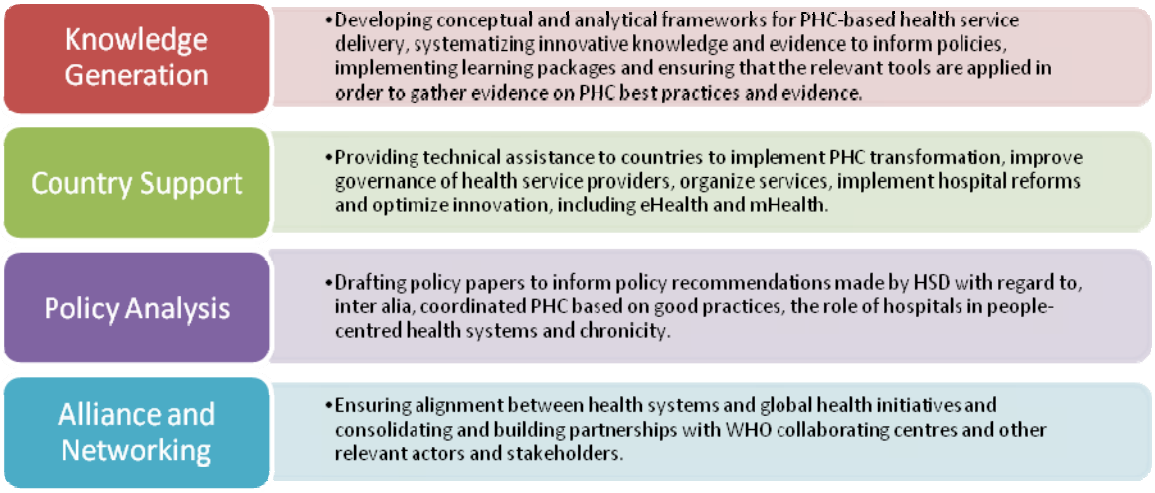
Policy analysis and knowledge transfer

19. Policy papers will inform the development of practical recommendations made by HSD on how to reform health services delivery, and how to coordinate health care provision based on international best practices and experiences in moving towards universal health coverage. This includes sharing and disseminating documentation, developing case studies, providing training, developing, adapting and validating tools, conducting peer-review, issuing publications, promoting policy dialogue at country level and carrying out global health initiatives.

Alliance and networking on global health initiatives

20. This focuses on alignment with and response to global health initiatives such as the GAVI Alliance and the Global Fund, among others. Building partnerships and networking with key actors and stakeholders are to be considered among the GDO's tasks, in order to scale up interventions, ensure that proposed activities are of international relevance, avoidance of duplication with existing initiatives and secure the GDO's role as an innovator within the Regional Office.

21. The diagram below summarizes these four key proficiencies.



22. Implementation of the above will contribute to the achievement of WHO's strategic objectives in the area of health systems and public health, in line with approved workplans, and will contribute to the second key priority outcome (KPO) of the Regional Office for the biennium 2014–15, on PHC-based health service delivery, "Member States have improved access to and performance of primary health care and other people-centred health services and have improved coordination, organization and management of health services providers in alignment with international policies and initiatives."

Endowment

23. The number of professional staff required for the GDO on PHC is estimated to be at least eight, supported by four administrative support staff. Expertise will include, inter alia, PHC organization and management, patient and disease management, continuity, integration and coordination of care, governance of health care providers, human resources for health and scale up of universal coverage. The professional staff will provide qualified expertise to support Member States in their efforts to design and implement PHC-based health service delivery, deliver capacity-building and training, and monitor and assess PHC performance, among others. The GDO will support the Regional Head Office in Copenhagen in responding to Member

States' requests with regard to strengthening PHC, implementing hospital reforms and adapting to emerging sophisticated epidemiological profiles (communicable diseases with chronic disease management, co-morbidities, etc.) in high-, medium- and low-income countries in the WHO European Region.

Budget

24. The biennial amount required will be US$ 6–7 million, including staffing, as well as activities and programme support costs (13%). Furthermore, the host country will be expected to cover the cost of the rent and upkeep of the Centre, including running costs and communications.

Strengthening partnerships, alliances and networking

25. The GDO, under the direction of HSD and the Director, Division of Health Systems and Public Health, will benefit from establishing, strengthening and consolidating partnerships, alliances and networks with relevant actors and stakeholders, in line with the WHO's global policy on partnerships. It will also work closely with national and subnational health authorities, thus promoting a multidisciplinary and inclusive approach.

26. Relations with WHO collaborating centres will be further strengthened and expanded. Current partners include:

- the Andrija Štampar School of Public Health, Zagreb, Croatia, designated as a WHO collaborating centre for primary care in 1983;
- the Netherlands Institute for Health Services Research (NIVEL), Utrecht, the Netherlands, designated as a WHO collaborating centre in 1987;
- the Department of Family Medicine and Primary Health Care, University of Ghent, Belgium, designated as a WHO collaborating centre in 2010; and
- the Organisation for Economic Co-operation and Development, World Bank, European Commission, Global Fund, GAVI Alliance, United Nations Children's Fund, and European Investment Bank.

27. It is also planned that the PHC GDO will benefit from the roster of experts under development by the WHO Regional Office in Copenhagen.

Priority countries

28. All Member States in the WHO European Region will benefit from the Centre indirectly (through intercountry and multicountry efforts) and directly (through country-specific support). Priority will, however, be given to countries with the greatest needs, particularly those in Central Asia, the Caucasus, the Balkans, and central and eastern Europe.

Conclusion

29. The establishment of a WHO Centre for Primary Health Care will substantially consolidate and expand the Regional Office for Europe's innovative contribution to developing and strengthening PHC and health services delivery in the Region. The Centre will provide

additional essential technical expertise and support to the Regional Office's existing capacities, in order to respond effectively to Member States' increasing requests for technical assistance for the establishment of people-centred health systems with PHC services at their core, in order to scale up universal health coverage.

Annex 1. Summary of the general principles and prerequisites of establishing geographically dispersed offices (GDOs)[2]

Background

The working document entitled,"Strengthening the role of the Regional Office's geographically dispersed offices (GDOs): a renewed GDO strategy for Europe" (EUR/RC62/11), was presented to the Regional Committee at its sixty-second session (RC62) in September 2012. The document defines and clarifies the role and functions of GDOs and describes the requirements and conditions that should be in place before a GDO can be established.

In its Decision EUR/RC62(2), the Regional Committee requested that the Secretariat make use of the content in document EUR/RC62/11 when considering options for new strategic areas and the establishment of potential GDOs.

Below is a summary of the conditions and requirements for setting up a GDO, as described in the document EUR/RC62/11.

Definition of GDO

A WHO Regional Office for Europe geographically dispersed office is any Regional Office technical centre located outside Copenhagen, which is an integral part of the Regional Head Office in Copenhagen and supports its work by providing evidence and advice for policy research, tools and capacity-building and actively contributes to the implementation of the Region's work programme in key strategic priority areas.

General principles

1. A GDO is established to address a specific and explicit element of a European Regional technical strategic priority area, as approved by WHO's governing bodies, where:
    a. substantial additional human resources and funding are needed;
    b. there is sufficient capacity at the Regional Head Office in Copenhagen to guide and lead the GDO's work programme (a strong core team and programme at the Head Office in Copenhagen with a responsible programme manager or division director);
    c. the GDO's main technical focus is clearly defined and easily and succinctly reflected in its technical title; and
    d. the GDO covers the whole Region and all 53 Member States.
2. The GDO is a part of a Division of the Regional Office in Copenhagen, and reports to the divisional Director. All the core functions of drafting policy, maintaining the necessary evidence base and engaging in strategic collaboration with Member States and partners continue to be performed by the Head Office in Copenhagen.
3. The GDO is responsible for specific technical deliverables that are incorporated into the Regional perspective of the Organization's Programme Budget and approved by the

[2] EURO/RC62/11 and EUR/RC62(2)

Regional Committee. They support the work of the Regional Office for the mandated strategic priority areas by:

a. generating knowledge and collecting and compiling evidence to help develop policies;

b. conducting research for the Regional Office's policies and programmes; and

c. developing tools and providing technical assistance and capacity-building for the implementation of the work programme.

4. The GDO is funded from the Regional Office's budget (which receives the agreed funding for the GDO from the host country and, where relevant, other partners).

5. The GDO is staffed by WHO technical and administrative personnel, who are governed by WHO rules, report directly and solely to the Regional Head Office in Copenhagen and are entitled to the privileges and immunities granted to international United Nations staff.

6. With regard to staffing, geographical balance across the whole of the European Region should be preferred and encouraged when setting up new GDOs, which should always meet at least the minimum requirements described below.

Prerequisites (and minimum requirements) for establishing a GDO

1. The Regional Office shall ensure that host country funding for the GDO covers all costs for staffing and running the GDO, as well as programme costs.

2. The minimum size of a GDO shall be at least 10 staff, which equates roughly to a minimum annual host country contribution of around US$ 2 million (depending on the grading of staff, cost of living in the host country and running costs). Consideration should be given to defining a more precise breakdown of the guideline of 10 staff members into professional and general service staff (in line with the staffing ratios at the Head Office in Copenhagen)

3. The host country shall second or fund a senior technical post at the Head Office in Copenhagen, to ensure full support, coordination and integration between the GDO and the technical programme in Copenhagen.

4. With regard to sustainability, the host country agreement must stipulate that the host country's provision of additional resources and expertise will be committed for a minimum period of 10 years, in order to enable a sufficiently robust programme, led by the Head Office in Copenhagen, to be developed and implemented. A "model" host agreement is attached, which also specifies that mid-term reviews will take place after 5 years. Continuation of the host agreement is by mutual consent and termination is by three months' notice in writing from either party.