

Health Centres: from Responsibility to Accountability

Jean-Louis Lamboray,
Julie McLaughlin, Reiko Niimi, and
Rudolph Knippenberg

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isa@itg.be

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Introduction

Health care systems should provide cost-effective technical interventions, but this cannot be their only aim. Clients require more than just technical resolutions to their health needs. Health services must ensure that clients make effective use of cost-effective interventions, and they must respond to clients' needs for care, that is, relieve their anxiety, help them cope with disease, and enable them to maintain their autonomy - their capacity to care for themselves. Clients expect more than just technical solutions for their disease. The expectations of people with AIDS highlight this fact.

How can this be achieved? This paper suggests that a key resides in the perception by health care providers of their accountability, and that accountability is most important at the health centre level, where the client first makes contact with the system. A system comprising a network of health centres -- each of which is accountable to a defined population for the provision of effective health services -- may represent

the most efficient means for ensuring effective coverage with an essential package of curative and preventive services, while simultaneously responding to clients demands for care.

Accountable health centres: a convergence of expectations

From care without cure to cure without care

"The physician's effectiveness is defined primarily by the impact that his presence has on the morale of the patient and his family". W James (1842-1900).

People have always looked for care when confronted with health problems. They have done so among family members and neighbours, but for centuries also, and in different cultures alike, they have sought 'professional' help in coping with ill health. In some places this was provided by

a shaman or through religious healing, in others a physician making home visits on horseback provided it. If demand for professional care is nothing new, neither is the concern of public authorities to help provide it. Already in 1620 the Health Officer of the city of Florence wrote "The number of poor patients has now increased to the extent that we should consider bringing them care in their homes for some time."

Relief from physical and mental pain and suffering is a considerable part of what can be done to care for those who are ill. It certainly has been the most ancient form of medical assistance, and, at least until the 19th century, the bulk of assistance that could be offered. Around the turn of the century new factors began to influence the development of health care. First, there was the accelerated development of medical interventions capable of changing the course of disease. These have subsequently gained world-wide prominence as a body of scientific techniques comprising what has been called 'cosmopolitan-type' health care. Second, in most parts of the

world, these techniques were introduced through hospitals, rather than through individual health care providers. This shift from individual to institution-based providers of care has reduced the importance given to human relations in health care delivery in the twentieth century.

Much has been gained through the evolution of effective means of providing cure, but something has also been lost. From care without the ability to cure, health systems have gradually evolved into providing cure without care. As the technical sophistication of methods for obtaining cure increased, key aspects of care –were increasingly seen as secondary. Anxiety relief, help in coping, help in dealing with disease and its consequences for the patient and his or her family were subordinated to the overriding importance given to the delivery of a technically effective cure. The result has been an increasing hegemony of the hospital as the prototype facility in health care provision. In the developed world, individual physicians -- the prototype care providers -- reacted by specialising, that is by adopting the *modus*

operandi of hospitals, and in the developing world, those who traditionally provided care were excluded from what became essentially a hospital-based, cure delivery system.

Correspondingly, people have become increasingly dependent upon medical care. They have been encouraged by the value placed upon professionally provided individual prevention and cure to effectively abdicate responsibility for their own health. In the developed world, people have become targets for technology; in developing countries people are targeted by programs sponsored by international donors. This is not what clients, nor providers desire.

The emergence of the health centre

In some arenas, there has been a strong reaction against this dehumanisation of medical care. In the West it has resulted in the emergence of a new kind of general practitioner or family practice specialist, one fulfilling the roles of both patient advocate and gatekeeper within the health

care system. Family practitioners tend more and more to work in the organisational set-up of a group practice -- a type of health centre. This arrangement improves quality and efficiency, both in terms of cure and care, but also facilitates the introduction of preventive and promotive services. The point is that the increasing attention given to the role of family practitioners exemplifies the need to balance the technical response with other aspects of health care, and thus reintroduce care along with cure and prevention.

Health centres in developing countries have been a traditional part of the system for a much longer time, but they have a different background. Having started out as 'dispensaries' -- acting as antennas of the hospital -- they rapidly became a key element in health care provision. These hospital roots, however, have led to confusion about what services a health centre should be expected to offer. This is at least partly due to semantic inconsistencies. In Senegal for instance, "health centres" are large facilities with beds, a kind of would-be hospital without the required

technical equipment. In Gabon, the project document for the construction of a large hospital mentioned that “for all practical purposes, (this hospital) will be called a Primary Health Care Centre”. Whether large or small, the mission of such health centres has usually been limited to one of cure, and the facility functions as the hospital’s poor cousin. In the best of cases it provides preventive as well as curative services. In much of Africa, entirely separate facilities have been developed for delivering preventive services outside of health centres, whereas in many areas of Asia “health centres” have evolved into facilities which provide preventive to the exclusion of curative services. The dimension of care -- to which traditional systems give at least a partial answer -- remains absent in the great majority of institutions. This, together with their failure to provide technical services of sufficient quality, has brought facilities known as health centres, particularly public health centres, into disrepute.

More recently, there has been a renewed interest in the potential of the health centre to

improve the delivery of health care. Its strategic position between the hospital and the community makes it an essential element of the decentralised approach to health care organisation and delivery. Critical to this transition is that the health centre evolve, not as a second best substitute for a hospital, but as an institution with its own specific mission: to provide effective care, cure and prevention.

This mission is identical in developed countries, where “health centres” build upon the role of the family practitioner, as it is in developing countries, where the health centre represents the evolution of the dispensary. The mission of the emerging health centre represents a convergence of diverse expectations for effective care, cure and prevention.

What clients expect from ‘health care

The expectations of clients go beyond that of technical effectiveness. First and foremost, they expect easy access to effective health care when needed.

This requires that services be geographically accessible, consistently available, affordable, and not involve undue waiting times, or psychosocial stress. The client expects the health centre to understand the need for care in a broader sense than simply resolving disease, and to address issues of anxiety, of suffering, and implications for his or her family, social and professional life. "Effective" health care may mean that the health centre has an answer to the client's problem: this may require equipment and drugs, or that the health centre is capable of enabling clients to resolve problems on their own. Or it may mean that the health centre refer the client them to more specialised services for a technical solution. Because clients expect cure and care for all their health problems, not only those judged to be problems by health care providers, health centres must also have the competence to deal with those aspects of care which are not strictly medical.

The client expects the health centre not only to make quality care, preventive and curative services available, but to do so in a way that is convenient, attrac-

tive and acceptable. It is interesting to note the different, but converging, experience from the developing and the developed world in this respect. In the developed world, the transition from individual private practices - which traditionally focused exclusively on curative services and the provision of care -- to group health centre practices, has increased provider involvement in preventive services. In many developing countries, dispensaries and health centres traditionally have assumed responsibility for preventive services, along with their role of decongesting the hospital system. Experience, particularly from West Africa, has shown that through providing quality care and curative services, health centres can gain the confidence of the population, and can then be the most effective and efficient way of reaching and sustaining high levels of coverage with preventive activities.

Finally, the health centre is expected to respect the way the client lives and defines his or her problem. This does not mean that the health centre responds unhesitatingly to every irrational demand or request; it does mean,

however, that there is a dialogue between the client and provider, to negotiate which of various options would be the most appropriate answer to the problem at hand. The objective is not for the client to hand over his problem to the health centre, but for the health centre to better enable the client to resolve his/her problem. At the end of the road there is no fundamental difference in clients' expectations in an affluent or a poor setting. The level of personnel and technical equipment may differ, and the response may be more or less sophisticated, but whether in London or in Laos, in Kinshasa or Khazakstan, health centres can respond to clients' demands for support in seeking care, cure and prevention.

The objectives of health professionals

The clinician defines effective health care as that which will resolve or preclude the medical problems of his/her client, whereas the public health professional defines effectiveness by the impact upon the health status of

the population. For individual health care provided by the clinician to achieve maximum effectiveness, it must be efficacious, comprehensive, continuous and integrated. For the public health practitioner to maximise community-wide effectiveness, health services must be appropriately utilised, and simultaneously, as resource limitations cannot be ignored, the care provided must be technically efficient.

What will enable the provider to achieve maximum effectiveness, and thereby meet his or her expectations for health care? Efficacy refers to the impact which the intervention applied could be expected to have on the patient's problem. Maximising the potential efficacy of an intervention will require that providers correctly identify their client's problem, and that together they correctly employ the most technically appropriate intervention. Comprehensive health care ("global" or "holistic" might be a more appropriate term) indicates that the responsibility of the provider is not limited to a technical response to the problem that is presented, but that the provider defines a response which

considers the social context of the individual. To be comprehensive does not just mean that providers offer a wide range of services, rather it means that they provide answers which fit within their patients' priorities, with the way the patient, or the patient's family, experiences his/her problem. The provider will try to accommodate the client's work schedule, or explain to a patient's spouse why bed-rest is required. Continuity of care ensures that the interaction with the client is not limited to the moment a request is made, but persists until the problem is fully resolved. If a patient with tuberculosis interrupts treatment prematurely, the provider will actively try to re-establish contact by, for example, making a home visit or contacting other members of the household. Integrated health care ensures that care, cure and prevention remain linked. When a mother seeks treatment for diarrhoea, the provider will use the opportunity to determine whether any of her children require immunisations. When a client receives treatment for a sexually transmitted disease, he or she would also receive condoms and counselling.

Public health practitioners will aim at appropriate utilisation of health care while maximising its efficiency. They expect providers to respond to the needs of their service population, and not limit their attention to only those who seek care. Faced with resource limitations, they also expect providers to weigh the allocation and use of their time and other resources in order to have the greatest benefit for the whole of the population for which they are responsible.

The aims of policy makers in concerning themselves with health care

Public policy makers are involved in health care because they are concerned with the wellbeing of their citizens, and recognise investments in improving health status as an investment in human resources. They are therefore concerned with maximising cost-effectiveness, that is, they want to reduce the disease burden as much as possible given the resources available. At the same time, they

are accountable to their constituents who demand access to quality health care. Both concerns overlap, and where policies have neglected their constituents' demands, improvements in cost-effectiveness are more difficult as clients lack confidence in the system.

Whether or not governments directly finance the provision of health services, policy makers and public authorities have a critical role to play in fulfilling these aims. As policy makers consider strategies for poverty reduction, they must address the needs of those who cannot afford health services. Providing prevention and cure, as well as care, is essential to improving the health and well-being of the poor. In order to improve the overall cost-effectiveness of health care services, policy makers should ensure that those who can afford to pay, as well as those who cannot, effectively utilise a package of essential health services.

Policy makers can ensure that national standards for care are established and enforced, and ensure that consumers and providers are made aware of the po-

tential role of health centres. They can inform the public about what they should expect -- and therefore can demand -- from a health centre. Changing the expectations of consumers will improve their decisions and behaviour regarding care seeking, and will place pressure on the providers and insurers of care to meet these expectations. Increased consumer pressure can reduce the need for administrative regulation and control.

Meeting the expectations: accountable health centres

Health care strategies based exclusively on hospitals and prevention campaigns fail to deal effectively with clients' or policy makers' expectations. Hospitals and other large institutions are incapable of providing easy access to integrated and comprehensive health care, or of ensuring continuity, nor is it likely that hospitals, campaigns, or unregulated private enterprise can provide this kind of health care efficiently. In hospitals -- or indus-

trial-size health centres such as those in Eastern Europe or Tanzania -- the client base is too large for the provider to know clients well enough, and to ensure continuity and coverage. Providers serving populations that are too small (e.g., community health workers, or family practitioners in countries with an oversupply of physicians) do not have the volume of work required to maintain technical quality and to justify the investment in human and physical resources. Providers' expectations are disappointed because they are unable to provide technically competent care; as they become under-utilised, they become inefficient.

Because health centres serve populations of a reasonable size (5,000-20,000), they have the potential to achieve a balance between care, cure and prevention, and to cost-effectively deliver these services. In both developing and developed countries, certain health centres have demonstrated that they are capable of responding to the expectations of clients, meeting the objectives of health professionals and fulfilling the objectives of policy makers. A

common characteristic of these facilities is the shift in personal accountability. Health centres and providers who assume responsibility for ensuring that not only their patients, but everyone in their service population gets the most out of the resources available for health care become accountable to their community for the services which they provide. In order to institute this shift system-wide, changing national standards, internal and external environments must support the development and implementation of accountability.

Development of the accountable health centre

There are now enough examples from project and country experience in the public (Guinea) and private (Belgium) sector, in urban (Thailand) and rural (Zaire) settings, in the developed (Scotland) and the developing (Benin) world, to show that accountable health centres are a realistic and feasible option. Lessons have been learned on the "how to" of accountable health

centres, on what works and what does not, on what makes the difference between a health centre that meets the expectations of the community it serves and a building that only carries the name.

The changes in perspective

When examining the differences between health centres and their predecessors it is clear that health care providers operating in health centres have much wider responsibilities than was the case in traditional settings. The mission of today's health centre is fundamentally different, and much more ambitious, than that of the traditional private practice

Table 1. Changing perspectives

	The perspective of the traditional Provider	The perspective of the accountable Health Centre
The responsibility of the provider is	to prescribe correct treatment for the client.	to facilitate reintegration of patients into their social environment, and prevent or control health problems.
The responsibility of the user is	to comply with the prescription issued by the provider.	to participate in decisions regarding treatment or control of the health problem, and adhere to the course of action agreed upon.
The population of concern to the provider is	Those who are ill.	Everyone within the community served, whether they are ill or well.
The costs of the health care provided	is not the provider's concern. He or she only has to provide the best treatment.	The provider takes into account the resources that are available or can be mobilised.
The provider is accountable	to his or her supervisors and peers.	Above all, to the population served.

clinician, the hospital or dispensary. Table 1 summarises the change in perspectives.

Transforming the mission of health care facilities and providers, is a gradual process, both in the maturation of what the mission should be, and in the development of tools that enable providers to translate that mission into practice. What an accountable health centre is about can best be understood by looking at this process of maturation and development as it has taken place among health professionals. The majority of health care providers enter the field of health care because, at least in some way, they want to assist people in difficult situations. Their training is oriented towards treating diseases; they are effectiveness-driven, wanting to utilise the best possible technical response to the patient's problem regardless of the cost. Many prefer to work within a hospital setting or to specialise, so as to expand their technical abilities. For such effectiveness-driven providers, a dispensary or clinic, lacking in sophisticated technology, may be a frustrating place to work.

From responsibility to accountability

Most health professionals do feel responsible for what happens to their clients. Health care is a way of making a living, but providers also generally accept the responsibility society attaches to their profession. One may interpret the health care provider's responsibility to mean simply giving advice or prescribing treatment to sick people who ask for help. But a number of pioneering health professionals have augmented that restrictive interpretation. In doing so they have redefined the nature and extent of their responsibility, becoming accountable to the community they serve. They have concurrently developed the techniques required to operate accountably.

PROVIDING COMPREHENSIVE CARE

"The nurse gave me the prescription, but I could not buy it because it was too expensive"

Patients may not be able to afford the drugs. They may not be

able to fully understand the correct way to use them -- witness the widespread inappropriate use of contraceptives in Nepal.

Or patients may not be able to follow the provider's recommendations because work or a family situation will not permit it. This is the case when workers refuse to take up sick leave for fear of losing their job, or when a mother in does not give "meat, eggs and milk" to treat her malnourished child, or when a villager discontinues a treatment that requires a 15 km walk to the dispensary, followed by a long wait for the nurse to give his injection.

The treatment offered may be only a short-term solution for an underlying problem, as when a battered child is treated for a fracture but the household situation does not receive attention. Although the provider's advice may be soundly based on what he or she has learned during medical training, this advice will fail to achieve results because it does not consider the particular situation of the patient.

Many health workers are

conscious of this, but react by continuing work as usual -- albeit with professional frustration. Others, usually those that know their clients and communities, try at least to adapt their prescriptions to what is possible for their patient. They engage in a dialogue with their clients, and try to reach a balance between what they think is best technically, and what will accommodate the clients' needs and priorities. This is what happens when a British family practitioner helps a patient choose between the pill and an IUD; when a nurse in Bolivia adapts the prescription to what the patient can afford; or when a clinical officer in Kenya defines a tuberculosis treatment schedule based upon the ease with which the patient can access a health facility.

Usually the circumstances of an outpatient consultation are not such that mere good intentions on the part of the provider will be sufficient to provide comprehensive - 'holistic' or 'global' - care. Some providers have therefore started to experiment with tools that would make it easier to ensure that the care provided is comprehensive. Rec-

ognising that good communication skills and empathy are not inherent to all providers, these institutions will have systematised ways which will make patients comfortable, to identify and respond to their individual needs. These include scaling down health units to a size that makes it easier to know the population and to have the time for dialogue with the patient; training health staff to communicate better with patients; training providers to look beyond presenting symptoms by, for example, employing Problem Oriented Medical Records as in the US; or rationalising drug prescription patterns to their patient's socio-economic background through, for example, community diagnostic exercises and the registration of clients. A consultation at such a health centre will be individualised and allow sufficient time to fully assess and respond to the patient's needs. The common denominator in these measures is that they assist in improving dialogue and empathy between provider and patient.

ENSURING CONTINUITY OF CARE

"I stopped the treatment because I thought I was cured"

It is not difficult for a provider to choose a drug regimen when treating tuberculosis; in most settings this is standardised. But the difficulty lies -- in New York and Bangkok alike -- in ensuring that the patient actually complies with the prescription throughout the lengthy course of treatment. Likewise, it is easy to tell a woman attending an antenatal clinic that she is at risk, and should deliver in a hospital. Ensuring that the patient does so is another matter, as transportation must be arranged so that she gets there in time, and sees a surgeon or an obstetrician who has all the relevant information.

Continuity of health care is difficult for the provider to ensure as much depends upon the client and the incentives within the system, but some health professionals have assumed responsibility for improving continuity. They have developed systems such as tickler files to identify treatment defaulters, referral letters and community funds which facilitate

evacuation to the hospital, home visits to trace defaulters, and treatment schedules which can be adapted to the patient's agenda. They employ appropriate information and communication systems to confirm that patients who are referred actually report to the hospital, and to ensure that upon discharge the patient receives appropriate follow-up care.

PROVIDING INTEGRATED CARE

"Yes, I have gone to the dispensary several times, but I did not know that I could get advice on family planning there."

Most providers respond to the problem presented by the patient who consults them, and do not go further. This standard behaviour is reinforced by training and by managerial decisions to separate functions according to disease program. The person who is responsible for treating diarrhoea may have little to do with immunisation, family planning or health education. If the patient needs assistance in these areas,

then he or she may have to wait in another line or return on another day.

To provide the optimal mix of curative, preventive, promotive or rehabilitative services in each situation, health care must be integrated. Health centres that are accountable to their service populations recognise this, and their providers feel responsible for providing integrated care. When treating the opportunistic infections of AIDS patients for example, the provider also counsels the patient on behaviour that will prevent the transmission of HIV to others. When a pregnant woman seeks treatment for a respiratory disease, the provider is also concerned with making sure that antenatal services are provided. Integration is especially important for achieving coverage with preventive services, for which there is less demand from patients. A way to enhance acceptance of preventive services is to build upon the relationship of trust that is developed during the curative consultation.

This naturally has consequences for the way in which work is organised at the health

centre. The physical layout and organisation of patient flow can affect the ability of the centre to provide integrated health care. An accountable health centre will have patient flow organised in a way that not only ensures integration, but also minimises discomfort or confusion for the patient.

In a number of countries, information systems, such as patient records, have been redesigned in order to increase support for the integration of health care services. Also important is the composition of the health centre team. Largely under the influence of different disease control programs, the first attempts at providing integrated health care have consisted of adding specialised personnel to the health unit with the expectation that it would increase the range of services provided. The results have by and large been rather disappointing. Work with small teams of multipurpose providers may be much more effective in ensuring that the range of services offered at the facility are always available.

EXTENDING RESPONSIBILITY TO THE COMMUNITY

The preceding section has explained that certain providers in health centres broaden their perception of responsibility towards their patients, and behave as if they are accountable to their clients. To them, quality health care is no longer defined by its efficacy only, but includes comprehensiveness, continuity and integration; it is no longer restricted to cure alone, but includes cure, care and prevention. But providing quality health care to only a fraction of the population (i.e., those who seek care) is not enough. Health care providers are confronted daily with people who attend too late or who come with health problems that could have been prevented. They know that quite a number - - in many countries the majority - - of potential clients do not attend at all. Providers who are held accountable to a defined population look for ways to mitigate such situations. They are responsible not only for those who consult with a problem, but also for those who do not consult and even those who are not yet ill.

In the developing world, where the majority of health problems are highly visible and can be resolved at low cost, many health care providers have aimed at secondary prevention, reasoning that by improving access to services patients might come at an earlier stage of their illness, thereby improving the probability of successful treatment. In this part of the world, improving access to services and ensuring coverage with preventive services were at the top of the primary health care agenda in the wake of Alma Ata. In many places, this resulted in a dense network of small facilities covering the entire population. Where physicians were scarce it meant delegating important, even difficult, tasks to nurses and medical assistants. This in turn has made it necessary to standardise management tasks and treatment strategies, to train and supervise, and to build confidence -- particularly among the medical establishment -- in the health centre's capacity to provide technically competent care. This same network of health centres has been used to ensure coverage with preventive services -- employing outreach strategies where

appropriate. In developed countries a different evolution has been taking place, but with a similar end result. Increasing resource constraints have encouraged individual physicians to pool their resources into group practices with an accompanying view to improving the quality of care and cure. It has also enabled them to assume responsibility for coverage with preventive services.

Resources for health are finite. Using them for patients on a first-come-first-serve basis is the behaviour of providers who only feel responsible for those patients who seek their care, as is the case in unregulated profit-driven practices. There is little reason for this provider to be concerned with what will happen when the resources are gone. Providers who are responsible for a defined population -- with present and future clients, with actual and potential users -- will rationalise their use of resources in response to the health needs of the entire service population. They will weigh the use of their time and of other inputs in order to provide the greatest benefit to the whole of the population for which they

are responsible. Provided they have sufficient autonomy, they will try to mobilise additional resources, from outside or from within the community, to ensure that the entire population effectively utilises quality services.

In order to provide efficient, effective and integrated health care while achieving maximum coverage, accountable health centres provide a defined package of cost-effective services. The definition of the package considers the cost-effectiveness of available interventions and the burden of disease within the population served. This ensures that patients have access to more integrated services, but it also implies that providers will not respond to every demand. There are certain services that will not be offered because they are not sufficiently cost-effective, because they are not demanded frequently enough for the provider to maintain competency or to justify the investment in equipment, or because they require specialised techniques which should be performed at a hospital. The package of interventions provided by the health centre can be accompanied by a “package” of

operating procedures, where patient reception, diagnosis and treatment are standardised, based upon defined international or local standards for health care, local experience, and the need to monitor technical efficiency. Patients then know what to expect in the way in which they will be attended to and how care will be provided.

Because it is concerned with resources, the health centre that lives up to its responsibilities will also look for additional resources (for example, selectively charging user fees, submitting grant requests, or lobbying for increased support for the type of services provided at health centres). The staff will monitor the inflow and use of resources in relation to costs, ensuring that the most critical inputs (e.g., drugs) will be financed, and that needy individuals are not denied access to care because of financial constraints. Taking up these responsibilities for the use of scarce resources cannot function without accountability.

Building a network of accountable health centres

Many countries already have a number of health centres that function as envisaged above. In others, new ones are being launched. Policy makers, however, are not interested in pilot experiences or unique events. What they want is success on a large scale, a change in the national norms. How can accountability become the standard rather than an exception to the rule? This final section addresses three issues: first, creating a health policy environment that eliminates constraints to accountability; second, developing the human and physical resources which are required to enable health centres to perform up to expectations; and third, proposing strategies for expanding health centre coverage so that the entire population can benefit.

Eliminating disincentives to accountability

Most staff, given a choice, would prefer to do relevant, interesting and gratifying work, yet in many places, health centre staff appear demotivated. This does not necessarily mean that they lack the competence or willingness to do their work properly. Unfortunately, health care policies often act as disincentives, or even as impediments to accountable behaviour, rather than creating an environment which encourages providers to act accountably. Widespread changes in the system will not be achieved by the few inspired providers who are willing to struggle against these impediments daily. Yet, policy environments can foster the natural inclination of providers to behave as described in the previous section. The elimination of constraints may be all that is required for providers to function as described in the previous section.

DECENTRALISATION

The first step to reducing disincentives to accountability may be to decentralise certain responsibilities and authorities. In order to feel and to be held accountable, staff must have the authority to make decisions, and enough control over resources in order to act upon them. Centralisation can deter health centres from becoming accountable to their service population. Centralised information systems do not consider the need for immediate corrective action on the basis of collected information, centralised ordering of drugs and supplies leave health centres with frequent shortfalls, and centralised planning is unlikely to incorporate the individual needs of communities.

SUPPORTING HEALTH CENTRE PERSONNEL

Favourable policies will recognise and reward staff who achieve coverage with cost-effective care, cure and prevention. Both developed and developing countries have difficulty convincing qualified staff to work in

health centres, particularly rural or isolated ones. In order to develop the positions of staff working in health centres or their equivalents, personnel policies must enable them to advance in their career tracks without specialising, and must compensate health centre providers sufficiently. In countries where family practitioners staff this level of care, policies should ensure that they teach in medical schools, where they can serve as role models encouraging qualified individuals to enter general practice. Similarly, if urban hospitals are the only place where staff can hope to have access to further training or housing, or to have their professional contributions recognised, they will be dissuaded from accepting positions in isolated health centres.

The commitment to health centres and the provision of cost-effective health care will also be reflected in policies regarding the production of staff. Reducing education subsidies for specialising, or the number of students allowed to specialise, will favourably affect the proportion of physicians who are suitably qualified to staff health centres. Many devel-

oping countries do not have the resources to place physicians at each health centre. In these settings, the production of multi-purpose health centre staff with a broad spectrum of skills will avoid the "specialising" of health centre staff which can thwart integration, continuity and efficiency.

INTEGRATING NATIONAL PROGRAMS

If health centres providing integrated care are to be the cornerstone of the health care delivery policy, program managers will have to change their modus operandi. When staff are required to report to separate central or provincial managers -- as happens when job descriptions are limited in scope to specific interventions or national programs -- accountability to clients takes second place. Rather than being evaluated upon service provided to clients, staff are assessed upon their ability to achieve the targets of national programs. This approach penalises staff who would otherwise provide integrated and comprehensive care.

Integration should not be perceived as making program staff

redundant. Program managers will still be required to monitor quality, develop and disseminate information on interventions, and encourage incorporation of appropriate interventions into integrated packages of care. For example, the detection and treatment of STD patients is the responsibility of the health centre; whereas STD program staff will make sure that treatment protocols are up-dated and disseminated. The TB Control Program will allow health centre staff to determine whether they will integrate their AIDS and TB outreach, but will assist them in defining criteria for making home visits.

BUILDING EFFECTIVE RELATIONSHIPS BETWEEN HEALTH CENTRES AND HOSPITALS

The complementary roles of health centres and hospitals within the system should be clearly defined so as to encourage collaboration rather than competition. Health centre staff should not be expected to provide technical follow-up for a leukaemia patient who requires inpatient care and access to a specialist

with the necessary equipment and technology. On the other hand, most patients with asthma are better treated at the health centre, which is closer to home and where the provider will be familiar with the patient's home and work environment. Access to a referral facility is essential for the health centre to be able to function effectively and remain credible to its clients; when a patient is discharged from the hospital and requires follow-up care, the health centre is the best placed to do so. Referral in either direction will require that the institutions share information and confer regularly.

Unfortunately, collaboration is almost impossible where hospitals and health centres have to compete for clients and revenues. Fees and insurance benefits should encourage clients to first seek care at the health centre. Simultaneously, clients must be convinced that they will be able to resolve their problem at the health centre, that it is personally cost-effective not to by-pass this level of care. If user fees or co-payments are charged, then they should be structured so as to reinforce this collaborative relation-

ship. Namibia's system of charges provides a positive incentive for the appropriate use of referral mechanisms by exempting properly referred patients from charges at subsequent levels of care. Mozambique's flat-rate system, in contrast, offers no such incentives.

If health centres, as the first point of contact, are to act as the patient's advocate within the system, and if this contact is intended to effectively address most of their health needs, then the system must be organised in a way which supports this role. Empowering hospitals as management units, and giving them oversight over health centres makes health centre providers accountable to the hospital rather than to their own service population. Organisational structures where hospitals manage health centres reinforce the image of the health centre as merely a satellite, buffer, or gatekeeper for the hospital. Placing hospitals at the centre of the organisation of the health care system contradicts the image of the health centre as the clients' advocate and primary source of care.

COMMUNITY INVOLVEMENT

Community involvement can play a major role in holding health policy makers and care providers accountable to clients' expectations. The community's involvement in health centre, as well as district or regional, decision making can reduce the need for supervision from above by increasing supervision from below. It can reinforce the image that the provider is accountable to a defined service community rather than only to supervisors or the system itself. Policies can ensure that mechanisms for involving the community are institutionalised through the formation of local health committees, regular meetings between health centre staff and community representatives, and community representation on health centre and district or regional health boards. Involving clients and the service community in the assessment of health centre staff performance should further reinforce the provider's understanding of their accountability.

Providers may require assistance in instituting mechanisms that will solicit community in-

volvement. They will require effective support, guidance, and arbitration by their supervisors for responding to community concerns and for improving relations with communities. Trainers and supervisors should be able to cultivate the specific skills required to facilitate community involvement. Clearly, health services cannot maximise their effectiveness if providers are unable, or refuse, to work collaboratively with their clients to maintain and improve their health. Leaders within the system must recognise the critical role of provider attitudes in improving the impact of health services.

Fostering health centre accountability

LEADERSHIP

Committed people -- civil servants or other -- who are willing to spearhead such policy changes can be found in every country. The challenge of setting up a team that can lead these changes is identifying those individuals who are willing to take the risks implied, who are in a position to influence the system,

and who are interested and able to discuss the technical agenda being addressed. Once such a team is formed, its task is to develop the vision for reform by translating it into a detailed technical agenda; what it proposes has to be concrete enough to enlist the enthusiasm of health care providers in the field. The team must have the capacity to mobilise national and international resources towards such reform, and should be given the responsibility for convincing other actors to support the process of change.

Professional organisations can help in defining, disseminating and enforcing standards for accountability. They have proven to be influential allies for change in Thailand where the Rural Doctors Association sustains the commitment of young practitioners to their work and communities; in Belgium where the Scientific Association of Flemish family practitioners has helped to improve the profession's image; and Zimbabwe, where the nurses associations are major factors in maintaining professional standards. Professional organisations can ensure

that individuals recruited into the profession have role models by, for example, lobbying for medical schools to include general or family practitioners among their educators. They can raise standards for providers by placing a value on accountability and by publicly recognising accountable providers. By guaranteeing that the professions are well represented, and making career advancement opportunities available within their field, professional organisations can develop the respectability of the multipurpose health worker or of the family practitioner. This is vital both for attracting new individuals to enter these professions, and raising client's regard for the work performed by this level of staff.

A CADRE OF HEALTH CENTRE STAFF

An individual or a core group of providers may be able to create a single, accountable health centre, but changing the national norm, rather than establishing a smattering of exceptional institutions, requires more than just a handful of exceptional health care providers. Individual health

care providers who have been able to transform their own facility into the type of health centre described here, or NGOs which operate facilities that meet the standards of accountability, can be enlisted to provide leadership or act as role models. Making such models highly visible both motivates others to strive to achieve new standards for care, and convincingly demonstrates how these standards can be implemented.

Curricula in many countries have increasingly recognised the importance of training providers not only in the technical aspects of cure and prevention, but also how to interact with and care for clients. The skills and attitudes required to act in an accountable way also need to be imparted through training. A provider may be willing to assume responsibility for a defined population, and may have been trained to provide integrated, efficacious care, but the tools which can be employed to ensure continuity, comprehensiveness, and efficiency are managerial and administrative, and therefore rarely part of a health care provider's education. Expanding the network of health

centres will require appropriate training of health centre workers, and modifying their work environment to enable them to apply their training. Multipurpose health centre workers will need to be trained in how to utilise tools which facilitate accountable care, and the supervision of their work should reinforce expectations that they will employ them. The training of family practitioners should ensure that they are familiar with and recognise the importance of these tools, even if the actual mechanics of information systems and patient follow-up tools will be delegated to other, non-medical staff.

Training and acquisition of new knowledge and skills is a constant that takes many forms for staff, not the least of which is support and advice, including technical information, from more experienced supervisors. In a system that supports the quality of health care delivered at health centres, supervisors are therefore individuals who have a particular set of skills, not simply those who have been within the system longer or who hold a higher rank. Without this gradient of different

skills and a sharing of the "mission", supervision may otherwise be associated with hierarchical control, and discourage sharing of information or transfer of skills.

Reorienting existing staff to assume accountability will be achieved through a change in implicit and explicit standards. Standards for providing care in an accountable manner can be mandated, and enforced through supervision and requirements for certification, but regulation and training are not sufficient in and of themselves to affect the desired change in providers' behaviour. Visible and accessible role models encourage health care providers to emulate their methods of operating, professional engagement, and attitudes toward clients and communities. Without exposure to how an accountable provider behaves, and without reinforcing the acceptance of accountability through promotion or public recognition of these providers, staff will be unable, or soon be unwilling, to perform according to expectations.

MOBILISING AND ALLOCATING RESOURCES

Launching a network of health centres or according decentralised authority to the health centre demands the concurrent provision of necessary logistical support and a functioning referral system, without which, the reform process could be quickly undermined. A crucial element in enabling the health centre to function accountably is the availability of essential drugs and supplies. Whether the network is based on public or private not-for-profit health centres, if facilities do not have access to a reliable source of essential drugs and supplies, the network will not be viable. When providers at health centres lack reliable sources of revenue, they cannot function accountably. Allowing health centres to generate revenues can reduce this uncertainty, but systems which expect communities to finance health centre care, while public financing continues to subsidise primary care received at hospitals, undermine the importance of the health centre and reduce the potential cost-effectiveness of the whole health care system. Rather,

the Health Centre network must consider a division of tasks and referral linkages with the hospital; for without reliable referral mechanisms, the health centre will not be credible and not be effective. The simplest way of achieving this is to embed the health centre network in an integrated district health care system that includes a first referral hospital.

Allowing health centres to collect and retain fees to cover their own operational costs can provide a buffer for emergencies or unanticipated needs, but the revenues collected through user fees are unlikely to fully finance care. Without the regular delivery of drugs, supplies and salaries, staff tend to sacrifice quality and coverage for the sake of their own survival. Access to essential drugs is not the only issue; running a health centre, and certainly launching new ones, will likely require a substantial investment. Nonetheless, a network of accountable health centres not only remains affordable, but provides more coverage and more relevant care per dollar than the alternatives, such as expanding tertiary hospitals, increasing the number

of programs, allowing unregulated private practice.

THE ROLE OF DONORS

It is possible to go a long way through local and self-financing, as some countries and NGOs have done, but it would be an illusion to think that all costs of transformation can be covered in this way. Often outside funds -- from governments, NGOs and donor agencies -- will be needed to support the initial investment, and to help cover recurrent costs. Donor agencies are increasingly recognising that if they want their investment to have a sustainable impact, they must move away from considering the development of health facilities as a target for their own agenda, and instead work with their partners to identify local priorities for reform.

Donors can play an active role in supporting new norms for health care, discouraging health policies which prioritise tertiary hospital care and encouraging adoption of those policies which will foster accountability in a district health care framework. They

can assist organisations or countries interested in prioritising health centres with the financial investment required to re-train staff and reallocate resources. Also, external agencies can expose leaders and health professionals to role models and the standards employed elsewhere, providing opportunities for providers to witness examples of accountability.

Achieving widespread coverage

Moving to a situation where an accountable health centre is the rule rather than the exception must be the objective if all of the population is to benefit. Whatever strategy is employed to achieve complete coverage, it should ensure that sufficient logistical support is ensured. Launching a big operation that becomes a failure could rapidly diminish provider enthusiasm and client confidence.

INITIATING THE CHANGES

The first hurdle health authorities must tackle is that of

resistance to change from other traditional actors in the health care system. The most vocal opponents tend to be disease control programs and hospitals. Transforming a system which has traditionally belittled the potential of health centres into one which relies upon them, will entail persuading all stakeholders that their own aims will be better served within the new system. A calculated effort to market the changes -- highlighting the ways in which health centres can best meet the array of expectations -- should target legislators, hospital administrators, regional and local managers, as well as providers and clients. The key entry point is the "district health management team. Where national management implementation capacity is weak, this may - paradoxically - entail strengthening the centre.

Changing the expectations of clients can be a powerful mechanism for establishing new standards. When clients are made aware of the potential role of health centres, and see examples of such institutions, they may begin to hold providers responsible for transforming their own health

centres. They can consequently put pressure on the public and private sectors to support their demands through financing and/or regulation. Organised consumer groups - such as community-based organisations in India and the Philippines, and mutual aid societies in Western Europe - have effectively lobbied for change from below. Accountable health centres learn to work with these groups as allies.

Exchanges with other countries that have successfully operationalised the principles in similar settings, has proven very effective -- through study visits, adaptation of training materials, and/or involvement of their own "leaders" as facilitators. Such exchanges can deepen policy makers', providers' and educators' understanding of the principles, as well as of the advantages or disadvantage of different managerial and organisational options, improve the relevance of training materials, and increase leaders' motivation through competition and exposure to role models.

FINANCING

Certain financing strategies can promote the replication of accountable health centres, but reallocating funds towards health centres requires major policy decisions that cannot be instituted overnight. If the care provided by health centres is a priority, then policies should seek to ensure that this care is fully financed. In some country settings this may require protecting publicly financed health centre budgets from inflation or devaluation; in others, the government may regulate the health insurance industry so that providers are encouraged to provide care which is comprehensive, continuous and integrated. Health centre providers who are made accountable for a defined population, informed of what resources they have, and trained in how to assess cost-effectiveness, are well positioned to ensure that the health care provided is cost-effective.

Efficiency, but also concern for equity and access to health care for the poor, makes it necessary for policies to regulate the distribution of health centres in

such a way that the most is made of the potential of the different sectors: government, private for-profit and not-for-profit. Situations with a government health centre on one side of the street, an NGO health centre on the other side, and two private clinics on the next corner, do not evidence the best use of scarce resources. Indeed, competition for patients in such circumstances could favour medicalisation and over-consumption rather than comprehensiveness and cost-effectiveness.

STRATEGIES FOR “GOING TO SCALE”

The first efforts to establish accountable health centres should be in a place i) that is visible; ii) where chances for success are high; iii) where the staff is motivated; and iv) where the referral hospital and higher level administrative support system (e.g., District Health Management Team or Regional Health Board) are likely to support the transformation. Strategically located examples of health centres which function accountably can demonstrate the potential for success, and expose staff and

communities to the ways in which accountable health care can be provided. Such demonstrations are so important to the wide-scale adoption of new standards that the first accountable health centres should probably be launched where chances of success are highest rather than where the need is greatest.

Strategically placed examples can have a mushrooming effect as providers are exposed to new and more satisfying methods of providing health care, and as clients agitate for health care which is comparable to that which they have experienced at “model” facilities. Diffusion of good practice can be cultivated by organising training sessions for new centres within accountable health centres, by publicising the work being done at model facilities, and through the feedback of satisfied providers and clients. Another strategy which can be employed to replicate model facilities, is to reach contractual agreements with providers on defined “packages” of methods and materials which have proven successful at providing accountable care.

Expansion may be accom-

plished through scheduled geographic phasing, or through strengthening those health centres and their supervising district teams that meet a defined set of criteria with training, new staff and supplies, and incorporation into the monitoring/supervision, logistics and financing systems established to support the new ways of operating. To enable the system as a whole to function accountably, a significant investment in training, equipment, supplies and infrastructure, or reallocation of existing resources may be required. This should be determined at the onset, and the phasing strategy should ensure that promises are not made which cannot be kept. Management and administrative structures themselves must be capable of providing necessary resources and support prior to incorporating new facilities or setting new standards for providers. At the same time, policy should not seek to perfect each individual facility before moving on to the next; the ambition must be to reach industrial scale if widespread coverage of the population with accountable health centres is to be realised.

Conclusion

The importance of an individual's first point of contact with the formal health care system, its potential to most effectively and efficiently address health problems, and to better enable clients to improve their own health status has brought increasing attention to the role of health centres and to the developed world's equivalent, family practitioners.

The notion of an essential package of preventive and curative health services for reduction of morbidity and mortality has now become main-stream. It cannot achieve its objectives if clients do not receive services, if they receive poor quality services, or if they receive services inefficiently. The majority of health interventions that comprise the essential package, will be most cost-effectively addressed outside hospitals, whether in a developed or developing country. The responsible facility however needs to have sufficient skills and resources. The population served has to be of a size both i) large enough to enable providers to maximise their effectiveness, and

to justify the investment in required infrastructure and equipment, and yet ii) small enough to enable them to effectively cover the entire population. And the health centre has to be accountable for living up to its responsibilities.

Accountable health centres offer a cost-effective mechanism for achieving improvements in health status while responding to the needs of clients for care, whether they are public or private, serving urban or rural populations, located in developing or developed countries. Whether systems are predominantly publicly or privately financed, governments have a stake in ensuring that their constituencies are served by a network of health centres. The intervention of public policy makers then becomes essential for defining a national agenda that recognises the role of health centres, establishing standards for the care that is provided, and developing the environment required to facilitate and promote accountability.

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