An important step towards Universal Health Coverage

Very often, on visiting health centers one hears that there is too much of work,and not enough hands and resources to do it; the reasons given for not being able to cover the catchment population for complete health coverage. The difficulty is that the health facility work is considered only for addressing the needs of those visiting the facility, which is treating illnesses. Ready answer is forthcoming to the inquiry for the number of patients seen that day or during the week.

This obsession with illness care and being overwhelmed with it, leaves little time for preventive services. Lack of realisation that preventive services, especially maternal and child health care, are the key to improve the health of the populations and the move towards universal health coverage (UHC), poses a problem. What little is addressed under MCH is often through vertical programmes such as immunizations, antenatal care and the like. Whilst it is possible to provide primary health care (PHC) in a comprehensive manner, tendency is to keep visiting the populations to provide single services again and again. Not only it is a waste of time and resources through duplication, people tend to believe that it is a treatment of some sort. Moreover, there is little time to explain how people should take the responsibility of their own health.

Primary Health Centers have at least the following responsibilities:

1. Attend to daily outpatients (Illness care, which seems to take everyone's time)
2. Attend to in-patients if any and referrals
3. Under Maternal and Child Health (MCH)
    1. Antenatal care
    2. Supervised childbirth (HC/Hospital deliveries)
    3. Postnatal care, including care of the newborn
    4. Family planning advice and services
    5. Immunisations
    6. Growth monitoring among Under-fives
    7. Adolescent Health
4. Chronic disease management
    1. HIV/AIDS
    2. TB patients (a&b often managed together under special programmes)
    3. Any other chronic diseases (Generally managed along with illness care)
5. Health education – a responsibility of all health workers under above mentioned services.

These services cover over 95% of all work expected to be carried out in a primary health center. If these services are provided to everyone, universal health coverage becomes a reality. Concentrating on MCH makes that possible, as it is abundantly clear that these

services reduce morbidity and mortality among women and children; and women and children are over 60% of health care recipients in any health facility.

Universal health coverage starts at PHC level. Unless equal importance is given to curative and preventive care in PHC, UHC is not possible.

Now let us see, what the workload is for an imaginary Primary Health Center (HC).
(*I have taken a population of a remote HC in Lesotho for this example workout*)

Catchment population of a HC = 18,500 (approx.)
National Crude Birth Rate = 25/1000 per year
Annual expected births in the HC population = 25x18500/1000; ~9/week
Say 60% come to deliver at HC = 277 (~5 deliveries/week)
Expected Complications of Pregnancy = 4625x15/100
(15 % of all births – It could be 15-25%) = 69 per year (~1/week)
at 25% = 116 per year (~2/week)
Expected deliveries requiring referral at 5% = 462x5/100=23 (~1/month)
(at 10%) = 462x10/100=46 (~1/week)
Antenatal Care (4 Visits) = 462x4=1848/year
If everyone attended ANC = 1848/52=35/week (or 7/day)
Postnatal Care = 462x4=1848/year
= 1848/52=35/week (or 7/day)
Family Planning (women 15-49, 51% of women) = 4812
(462*3=1386 are pregnant, lactating or trying for pregnancy) =4812-1386=3426
= 3426/12 = 286/month
Child Immunisations (1st Year of births*3) = 462x3=1848/year
= 116/month (if all attended)
1-3 years (avg. 2/child) = 462x2x3=231/month (all)
Growth Monitoring (Under-fives) = Along with Imunisations

Adolescent Health will go with School Health programmes and some of the services mentioned above.

Workload summary:

1. Outpatient = ~100/day
2. MCH work at HC

Deliveries = 1/day
Complications = 1/week (referral)
Some ANC/PNC work = <10 patients/week
3. MCH (HC & outreach) ANC&PNC (all women) = 300/month
Family Planning = 286/month
Immunisation and Growth monitoring (U5s) = 231/month
4. Chronic Diseases (TB/HIV/AIDS national progs.)= Managed by special teams
5. Health education forms an integral part of all above mentioned services.

The workload calculated above is for the total population, considering everyone would avail these services. In practice the actual workload will be much less. However, if UHC becomes a reality, this would be the maximum expected work at a HC. If HCs are well organised and

supported by the district, this amount of work is feasible from the available manpower at HCs.

It is clear that the MCH services constitute the main bulk of workload, which requires planned management. Either through outreach clinics in the villages at periodical intervals (best monthly, as it suits Immunisations and growth monitoring schedules) or practical distribution of service provision between HC and special MCH clinics, it is possible to deliver these services. Further discussions on possible ways of doing it, can be found under old items. (see under Old Items)

The outreach methodology was used in Laos project. Apart from technical support from the project health team, all work was carried out by existing government health center teams. A comprehensive MCH service provision to the resettled population resulted in great improvements in health state of the whole population. (see under Blog > Collaboration with Government Health Services)

Conclusion:

1. Universal Health Coverage must start at Primary Health Centers (PHCs);
2. Workload assessment is a tool which will benefit PHCs in enabling UHC to its catchment population;
3. Age sex distribution of the health center population at individual level is essential. It allows planning of services, service provision and evaluation of the strategies used;
4. Age sex register of a HC population allows individual care for preventive services, especially for MCH care, e.g. Immunisations, growth monitoring, family planning etc.;
5. Population sub-group disaggregation allows each section of population to be assessed, allowing population coverage and monitoring;
6. Health indicator information is generated with ease and is available at short notice for reporting;
7. UK is a good example of the use of this methodology, where general practice addresses day to day needs of illness care. A team of midwives provide domiciliary care for MCH and *other services* with support from the general practitioner (GP); who has the overall responsibility of his/her registered population. Each individual (usually families) are registered with their GP, resulting in almost whole population coverage, allowing UHC.