

Editorial

Primary Health Care in the 21st century: primary care providers and people's empowerment

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International health debates often confront enduring values with new realities. The events and publications surrounding the 30th anniversary of Alma Ata,¹ the Primary Health Care (PHC) focus of the 2008 World Health Report and the report(s) of the Commission on Social Determinants of Health illustrate the durability of PHC values such as equity, self-determination, participation, *trans*-sectoral collaboration and the right to health (Gilson *et al.* 2007; Chan 2008; Lawn *et al.* 2008; Reich *et al.* 2008; Walley *et al.* 2008; World Health Organisation 2008; Hanson *et al.* 2009). Taking into account recent transitions that are changing the relationship between primary care providers and their patients, we examine the role providers can play in enhancing people's individual and collective empowerment, an important but rather neglected component of PHC (Walley *et al.* 2008).

Transitions affecting the patient–provider relationship

The demographic and epidemiological transition (Beaglehole *et al.* 2008; Frenk 2009) led to a growing population segment with life-long conditions, creating needs beyond the traditional sphere of medicine. For these people, more than for patients with acute and short-lasting health problems, disease management is but one aspect of life, next to employment, family, enjoyment of life and the desire to remain independent. They pursue satisfactory rather than maximal control of physical parameters of

health. This set of needs implies a partnership between provider and patient, which also takes into account the support networks and communities in which individuals are embedded. Moreover, as many people with chronic conditions have become 'experts' in their own condition, the advice from health providers is complemented with information and support from fellow patients, support networks and, increasingly, the Internet. Self-management strategies for chronic care have been popular for a while now in high-income countries (Holman & Lorig 2000), but initiatives towards more control for patients also develop in low-income countries. Examples include self-help groups for diabetes patients (Wientjes 2008) and task delegation to expert patients in HIV/AIDS care (Van Damme *et al.* 2008). Increasingly, patients expect a broader approach from health care providers than the 'classical' one learned in medical or other training schools.

Institutional mechanisms also underwent drastic transitions. In the 1980s and 1990s, the response to the weak performance of many health systems in low-income countries (Blaise & Kegels 2004; Meessen *et al.* 2006) was to introduce reforms varying from full-blown privatisation, the introduction of purchaser–provider splits, to contracting, performance-based financing or combinations of these. Even without specific reforms, passive marketisation and a boom of the informal sector occurred in many countries (Segall 2000; Bloom & Standing 2001; Bloom 2004). All these institutional reforms and trends had in common that the voice of the user (or 'customer', 'client' or 'consumer') of health care and health services began to matter more.

New technologies and globalisation have multiplied the sources and flow of information, and access to information for the public has increased, although there remain great

¹This article fits in the anniversary events, since it elaborates on discussions held among 80 health system researchers during a workshop in Antwerp in November 2008, about PHC in the 21st century (Institute of Tropical Medicine 2009).

inequalities among and within countries and populations. Information on health and health care has become as pluriform as the health care system itself (Bloom & Standing 2001). However, to filter this information on relevance, quality and reliability is a major challenge (Lucas 2008), as the knowledge gathered from the internet and other sources remains fragmented and suboptimal. The marketisation of health information may also induce a demand for the newest 'trendy' therapies, contributing to increased consumerism and sometimes confronting providers with unjustified and unjustifiable demands.

In the internet era, people obviously also have more opportunities and channels for interaction, triggering the growth of organisations and networks at all levels for self-help, peer support, advocacy and sharing of experiences. 'New social media' tools complement existing formal participatory platforms like community health committees. This contributes to increased voice for patient groups, especially at national level and in certain disease-specific programmes. In the interaction with providers of general multipurpose health services, patients groups are perhaps less influential, at least for now.

Last but not least, the patient provider relation is strongly affected by the social position of both patient and provider in society. With variations among countries, the growth of an educated middle class, more likely to express claims, and the decline of social status of health professions have affected the social positions and thus the relation between patient and provider.

To summarise: even if a great variety exists in the way these transitions occur and affect people, to some extent, they all seem to generate the need and the possibility for more patients to become more vocal towards health providers.

Primary care providers' contribution to empowerment

The concept of empowerment has multiple interpretations, a generic description being individuals or groups who gain mastery over their own affairs, by an increasing capacity to make choices and to transform those choices into desired actions and outcomes (Wallerstein 2006). Applied at community level, it focuses on power, democratisation and the right to self-determination (De Vos *et al.* 2009; Yamin 2009). In health, the concept was first used in the domain of health promotion, referring to helping patients to take responsibility for their health goals by improving their knowledge, skills and attitudes (Feste & Anderson 1995). Later, it was also introduced in clinical care, more specifically for chronic diseases (Arnold *et al.* 1995; Bodenheimer *et al.* 2002). The report on social determi-

nants of health recognises the effect of empowerment both at individual and at community levels (Gilson *et al.* 2007). Although a popular notion, empowerment remains limited in practice, partly because it is difficult to grasp in terms of concrete outcomes, but probably even more because it entails the transformation of power relations between providers and individual patients and between professionals and the broader community (Herbert *et al.* 2009).

Patient empowerment at primary care level calls for a departure from the prevailing medical and bureaucratic culture in many health systems. In high-income countries, family medicine (with its focus on patient-centred care) and chronic care models tend to induce some shifts in this culture; in low-income countries, there could be similar levers (Howie *et al.* 2000; Van Dormael *et al.* 2007, 2008). Health providers anywhere in the world are more likely to modify their traditional relationship with patients, if it fits with their paradigms and interests. Therefore, the dissemination of the evidence on clinical effectiveness of particular empowerment strategies (Wallerstein 2006) is important, to show that, instead of merely being cumbersome, emancipated patients are a resource for better health outcomes (Shaw & Baker 2004).

Of course, patients' empowerment means that they can (and often do) legitimately disagree with their care provider. This requires a change in attitude among providers, to feel responsible *to* their patients, instead of responsible *for* their patients (Anderson & Funnell 2005). Primary care practices in the United States have experimented with interventions to facilitate such a shift. They found that patients who wrote down their needs, concerns and abilities in little notes for their providers before consultation felt more in control afterwards (Griffin *et al.* 2004). In Belgium, primary care providers have developed a method to search the internet for information together with the patient during a consultation. This enables the patient to find the right information about his condition and treatment (Dietrich 2005). Patients can be provided with easy diagnostic materials and decision aids for use at home, helplines to ask advice and tools to remember medication or appointments (Tomasi *et al.* 2004; Lucas 2008). The HealthLine service of GrameenPhone in Bangladesh allows an interactive teleconference at any time between a subscriber seeking health-related advice and a licensed provider. Such initiatives might support the awareness, assertiveness and stress management of patients, all indicators of empowerment (Arnold *et al.* 1995; Lucas 2008), but their potential in other settings needs to be further investigated.

Primary care providers have a responsibility beyond the individual patient, towards the community (WHO 2008; Frenk 2009), which implies a role in the empowerment of

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(certain groups within) communities. Because many providers have a focus on individual patient care, they are probably more motivated when they start from the multiple care needs of patients and from their specificity as the hub of coordination in a network around the patient (WHO 2008), and then reach out to community- or civil society-based initiatives. Thus, the WHO framework for care for chronic conditions identifies specific roles for community partners, family and health care organisations (World Health Organisation 2007).

Community empowerment also entails a component of self-determination and a stronger community voice in relation to other actors in the health system. Primary care providers can help the community in its process of self-determination, by providing guidance to find the right information and to formulate its needs vis-à-vis other actors. However, providers do not always feel sufficiently 'part of the community' to join forces, or they may be ambivalent towards the community's goals and processes. Therefore, community empowerment requires context-adapted strategies, both for providers and for population, such as for instance the Indian Rural Health Mission, which gives authority to the community to question and monitor government providers and to allocate untied grants (Ministry of Health and Family Welfare 2005). Ideally, these locally adapted strategies should stimulate the organisation capacity, leadership and agency of people, and foster the emergence of (counter-)power in the community (Criel *et al.* 2005).

If primary care providers are to contribute to people's empowerment, then the institutional conditions should support them in that direction. This means the allocation of time and money to listening, coordinating, guiding and communicating. It also implies a human resource management that creates the conditions, an organisational culture and socialisation processes in which such empowerment is valued.

With the growing tendency towards evaluation of performance based on results, we should reflect on how to formulate the desired results (in terms of empowerment) and how to design the incentive structure to reach these results. In other words, if empowerment is part of expected performance, then we need methods for its assessment. The literature about this is scarce. The patient questionnaires to measure empowerment at individual level have a limited reliability and validity (Herbert *et al.* 2009), and the only documented applications that we could find for settings other than high-income countries (Howie *et al.* 2000) were in China and Zimbabwe (Van Eygen *et al.* 2007; Fung *et al.* 2009). Perez *et al.* have recently elaborated and applied a framework to assess the process of community empow-

erment in Cuba (Perez *et al.* 2009). We propose to prioritise the design and testing of indicators to assess the results of empowerment strategies, such as the development of personal skills, the creation of a supportive environment, the quality of community action and participation, public policies and institutional relations (Wallerstein 2006), with both universal and local elements (Wallerstein 2006; Van Eygen *et al.* 2007).

Conclusion

Primary care providers in the 21st century are confronted with transitions that affect the patient-provider relation and with the need to redirect certain care relations towards a more horizontal advisory 'partnership' between equals. In this new context, primary care providers could develop their specificity and prove their relevance through a renewed focus on empowerment. Empowerment is indeed not a new concept and dovetails with goals like equity and participation, although it lays different accents. It derives its importance from a democratic viewpoint (more participation and assertiveness) and from an instrumental one (better health outcomes).

We have made suggestions on how to support primary care providers engaging in empowerment. When starting at the level of individual patient care, providers and patients can directly see gains and benefits for individuals, especially but not only for those with chronic diseases. However, with many health problems rooted in structural inequities, there is a need to expand empowerment beyond the individual level (Gilson *et al.* 2007; De Vos *et al.* 2009).

The opportunities for empowerment are greatly influenced by organisational and general context aspects, like the providers' status and payment method, or the accountability structure of the bureaucratic and political system (Yamin 2009). The empowerment of certain groups in society may be perceived by others as an unwelcome shift in the power balance and create resistance. Empowerment of patients and communities thus needs different approaches, directed at the care supply and demand sides, and an enabling context.

As researchers, we propose an empowerment research agenda with the following components: to refine and validate measurement tools for empowerment, with universal elements and guidelines for the adaptation to the local context; and to document strategies for the empowerment of patients, groups and communities. The description of these strategies should include the intended and unintended effects and the influence of contextual elements, teasing out the mechanisms in the interaction between strategies and contexts.

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