

Back to the future with PACK

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On 25 October 2018, the world's governments convene again at Astana on the 40 anniversary of the Declaration of Alma-Ata. The draft Declaration for this Second International Conference on Primary Care reaffirms the principles of the original Declaration. Behind the slogan of 'Health for All by the year 2000' was the commitment to provide universal access to basic comprehensive primary care services built on a moral case—the human right to health, the right and duty of people to participate in planning and implementing their healthcare, and the unacceptable injustice of inequities between and within countries. Concerns regarding the breadth of the vision, lack of operationalised plan or indicators of progress led, in 1979, to what has been described as a counter-revolution; Selective Primary Health Care.^{1 2} With scarcity, the argument went, choices were inevitable. When these came, they were radical—a focus on just four interventions linked to maternal, newborn and child health.

Four decades on, and we are 'back to the future'. Drafts of the Astana Declaration have asserted that a strengthened primary healthcare approach is essential to achieving universal health coverage, forming the core of integrated service delivery, and providing care that is 'continuous, comprehensive, coordinated, community-oriented and people-centred'. It is another bold vision, requiring political will, planning and persistence for full realisation. Half the world's population still lacks access to comprehensive basic healthcare services, and 1 in 20 have no access at all³. Primary healthcare services have been slow to reform their acute care models to the challenge of providing quality continuing care for chronic diseases, in response to the inexorable transition in global disease burden.^{4 5}

WHO Director-General Halldan Mahler asked two questions of member states in Alma-Ata in 1978,¹ testing their readiness to introduce radical health system changes, and to fight political and technical battles to overcome barriers to universal primary healthcare. His questions remain relevant, and

the Practical Approach to Care Kit (PACK) provides some of the answers.

PACK is intensely practical and pragmatic, imbued with the culture, ecology and practice of primary care. These providers' needs were paramount in PACK's genesis and iterative development. Non-specialists attend to the full range of health problems that afflict their communities, with little idea of what to expect as the patient walks through the door. Consultations are very brief. All generalist cadres therefore approach assessment, diagnosis and management differently to specialists.⁶ Diagnostic hypotheses are, of necessity, made early in the consultation based on presenting complaints, pattern recognition and probabilistic reasoning, refined by targeted history-taking and examination, and confirmed or refuted through strategies including 'test of time', 'test of treatment' and investigation.⁶ Many of these elements depend on experience, enhanced by the one advantage enjoyed by primary care—prior knowledge of patient and family histories and circumstances. They represent a highly honed skill set that is unique and hence, specialised. PACK strengthens these skills and this way of working, increasing the probability that the care that is delivered is evidence-informed, safe, efficient and effective.

We come now to the radical elements of the PACK approach. First, PACK is uniquely comprehensive in its scope. It is in the words of a South African nurse 'a tool for every day for every patient'⁷ hence precisely meeting the Astana requirement for quality care meeting the majority of needs. Second, generalists are bombarded by well-intended disease-specific and system-specific guidance that does not address multimorbidity, and subverts rather than supports the integration of care. PACK is meticulously 'evidence-informed' through regularly updated reviews of all relevant guidelines (BMJ Knowledge Centre's Best Practice, WHO and other sentinel guidelines), but wears its scholarship lightly, focusing on what providers need to know, and ensuring integration of guidance across conditions that may be comorbid. Since



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PACK successfully synthesises and incorporates all of this evidence at the level at which it needs to be understood, it can ignite ‘a bonfire of the guidelines’ at least from the shelves of primary healthcare facilities where they gather dust. Third, PACK eschews the prevailing model of off-site in-service training in favour of facilitated adult learning at work. This grounds the learning experience in the reality of everyday work and respects healthworkers’ professional skills. Team training creates communities of practice, making it more likely that knowledge and skills are retained despite staff turnover, and are enhanced over time. It supports the Astana commitment for health-care workers to be ‘working in teams with competencies to address modern health needs’. Fourth, most modifications to PACK Global through the localisation process address health system specificities rather than limitations to the generalisability of evidence.⁸ Colour-coding transparently identifies international variations in regulation and policy regarding scope of practice for different healthworker cadres, access to essential medicines and investigations. These impose limits on content that can feasibly be delivered, but can also provoke reconsideration of policies to better support task-shifting and task-sharing; essential mechanisms in the drive for universal health coverage.

PACK should be at the heart of the actions that follow the Astana Declaration, but needs to be weaponised for full impact. This requires a funded strategy and plan to meet demand for localisation and support with implementation. WHO and other intergovernmental normative agencies have been slow to leverage potential for non-state actors, such as the PACK partnership, to work at scale, and catalyse and effect change.⁹ Their explicit support will be critical to wider adoption. Finally, while health systems strengthening interventions, and a monitoring and evaluation component are pillars of the PACK strategic approach, these need more work. Neither routine Health Management Information Systems nor Demographic and Health Surveys currently provide adequate or appropriate data to monitor the impact of innovations like PACK on the coverage, quality and outcomes of care.

Implementation research is needed to better define the governance, management and workforce non-technical skills that are required to promote sustainability and deliver continuous quality improvement.

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