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Beyond Facility Counts

Aligning Primary Care Resources with Real Service Workload in Jordan

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8.5×

Difference between the highest and lowest governorate averages for annual GP treatments per Ministry of Health center in 2024 [1].

The decision

Add a workload review to primary care allocation decisions before choosing whether to expand premises, adjust staffing or change service hours. Facility counts describe the network, but cannot show how much care each site can deliver or where patients experience difficulty obtaining care.

Executive message

Jordan needs a planning process that reads population need, recorded use, workload and service mix together. Governorate averages can identify where a closer assessment should begin. They cannot determine which center should gain or lose resources.

This brief proposes a four lens planning approach and a practical sequence for testing it. The immediate policy priority is to investigate the causes of variation while protecting geographic access.

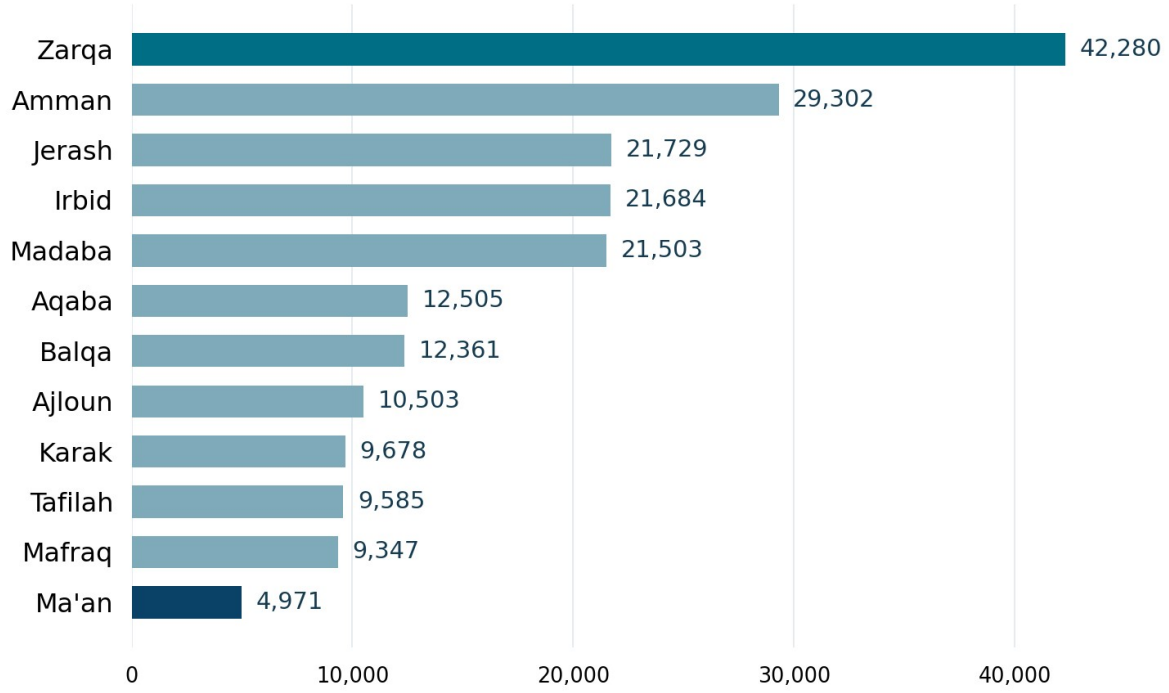
For Ministry of Health planners, health directorates and primary care managers

01 / EVIDENCE

Recorded activity varies across governorates

In 2024, 625 Ministry of Health centers recorded 11.46 million GP treatments across 12 governorates [1]. These are treatment encounters, not unique patients or all primary care activity.

Annual GP treatments per health center in 2024



Source [1], Tables 1:4 and 1:8. Author calculations. Centers include comprehensive, primary and sub-health centers. Values are governorate averages rounded to whole treatments.

How to read the difference

The highest average was 42,280 in Zarqa and the lowest 4,971 in Ma'an, a ratio of 8.5 [1]. These totals per center are a screening measure of recorded activity, not clinical workload adjusted for staffing or consultation complexity.

A busy center may have more staff, longer hours or a different case mix. A center with fewer encounters may preserve essential access for a dispersed population. Neither observation establishes whether capacity is adequate.

The economic question

Which feasible change would improve timely, appropriate care most for the resources available? The answer requires local evidence about bottlenecks and access. Higher treatment volume alone is not a measure of health benefit.

02 / INTERPRETATION

Use four lenses before allocating resources

The ICHEPI Four Lens Primary Care Allocation Approach is a proposed planning aid. It is not a validated index or a funding formula. Use the lenses together to explain a service problem before selecting an intervention.

Population need

Assess age, chronic illness, deprivation, settlement patterns and travel time. Recorded use cannot reveal everyone who needs care. Low activity can reflect barriers to access as well as lower demand for Ministry of Health services.

Utilization

Review encounters by service, patient residence and referral route. Examine repeat visits and the availability of other providers. Separate appropriate follow-up from avoidable repetition before treating higher volume as a planning objective.

Facility workload

Relate activity to staffed clinical hours, team composition, opening hours and waiting times. Governorate averages should lead to facility-level checks because they can conceal variation within the same governorate.

Service mix

Account for prevention, maternal and child health, chronic disease management, urgent care and outreach. Compare facilities with similar functions; encounter counts do not capture the time or resources required for each service.

Match the response to the constraint

Finding after local review	Response to assess
Long waits and insufficient staffed hours	Compare staff deployment, appointment changes and extended hours.
Long travel times despite low activity	Assess outreach and transport options; preserve essential local access.
Missing clinical functions or equipment	Assess targeted service additions, referral support and equipment.
Persistent space constraints after service review	Appraise expansion against alternatives, including recurrent costs.

03 / ACTION

Make workload review part of annual planning

First 90 days

A proposed Ministry of Health planning and health-directorate team would reconcile facility lists, service definitions and reporting completeness. Build a governorate dashboard with drill-down to facilities, adding staffed hours, waiting times, service mix and travel-time information where available. Record gaps explicitly.

Months 3 to 6

Select contrasting catchments for a diagnostic pilot. Review patient flows and staff deployment with local teams. Compare targeted options using incremental costs, expected service effects and implications for equitable access. Do not move resources solely because a governorate average is low.

Months 6 to 12

Evaluate the selected changes before wider adoption. Track waiting times, continuity, unmet need, staff workload and spending against baseline. Where feasible, use comparison facilities and account for seasonal changes. Retain interventions only where evidence supports their value and access safeguards.

Data and methods

This brief uses a descriptive 2024 cross-section. Center counts by governorate were summed across three facility types in Table 1:4; GP treatments were taken from Table 1:8 of the Ministry of Health Annual Statistical Report 2024 [1]. Treatments divided by centers give annual activity per center. The largest value divided by the smallest gives 8.505, reported as 8.5. No causal effects or efficiency scores were estimated.

Limitations include aggregation, differences in facility size and functions, repeat encounters, patient flows across boundaries and the absence of staffing and need adjustment. Other providers and non-GP services are outside the activity measure. The brief does not estimate unmet need, quality, savings or an optimal distribution.

Source and publication information

[1] Jordan Ministry of Health. Annual Statistical Report 2024. Primary healthcare chapter, Tables 1:4 and 1:8. Official report

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