

Review of 40 years of primary health care implementation at country level

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Acronyms

CD	communicable diseases
CBO	community-based organization
CSO	civil society organization
GDP	gross domestic product
GP	general practitioner
HIS	health information systems
ICT	information and communications technology
MDG	Millennium Development Goal
NCD	noncommunicable disease
NGO	nongovernmental organization
NSA	non-State actor
OOP	out-of-pocket (expenditure)
PHC	primary health care
SDG	Sustainable Development Goal
UHC	universal health coverage
WHO	World Health Organization
UNICEF	United Nations Children's Fund

Executive summary

Background

In the Alma-Ata Declaration of 1978, the signatory Member States to this seminal document “express[ed] the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world”.¹ In so doing, they declared their commitment to the broad principles of primary health care: health as a human right that is the basis for economic and social development as well as world peace; health as not merely constituting the absence of disease or infirmity; health equity both between and within countries; and roles and responsibilities of governments for the health of their populations and of the people to participate in the planning and implementation of their health care. Setting a goal of “the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”, Member States placed primary health care at the centre of this goal and articulated the core elements of primary health care described elsewhere in this report. Member States underlined the need “to exercise political will, to mobilize [their respective countries’] resources and to use available external resources rationally”, and for WHO, UNICEF and other international organizations to support them in their efforts.

Although the concept of primary health care has been operationalized in multiple ways over time and in different contexts, for the purposes of this review, the comprehensive definition articulated by WHO and UNICEF in their shared vision document for primary health care provides the lens through which global progress, achievements and success stories, best practices and key challenges were identified in this review. This definition describes primary health care as:

a whole-of-society approach to health that aims to ensure the highest possible level of health and well-being and their equitable distribution by focusing on people’s needs and preferences (as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment.²

Primary health care is clearly differentiated from the closely-related term “primary care”, which is the organization of essential health services principally at the first level of care. As such, primary care is one important element of primary health care, but is also clearly distinguished from the much broader concept of primary health care as an overall approach to health.

On the occasion of the fortieth anniversary of the Alma-Ata Declaration, participants at the Global Conference on Primary Health Care held in Astana, Kazakhstan on 25 and 26 October 2018 issued the Astana Declaration “reaffirming the commitments expressed in the ambitious and visionary Declaration of Alma-Ata of 1978 and the 2030 Agenda for Sustainable Development, in pursuit of Health for All”.³ In doing so, they committed to “make bold political choices for health across all sectors”, “build sustainable primary health care”, “empower individuals and communities” and “align

¹ Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 (https://www.who.int/publications/almaata_declaration_en.pdf, accessed 28 October 2019).

² A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization and the United Nations Children’s Fund (UNICEF); 2018 (WHO/HIS/SDS/2018.X; <https://www.who.int/docs/default-source/primary-health/vision.pdf>, accessed 28 October 2019).

³ Declaration of Astana. Geneva: World Health Organization and the United Nations Children’s Fund (UNICEF); 2018 (WHO/HIS/SDS/2018.61; <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>, accessed 28 October 2019).

stakeholder support to national policies, strategies and plans”, namely through knowledge and capacity-building, human resources for health, technology and financing.

Within this context, a review of 40 years of primary health care implementation at country level was requested by the WHO Executive Board at its 142nd session in January 2018.⁴ The terms of reference for this review were presented to the 144th session of the Executive Board in January 2019 and were subsequently noted by the Board.⁵

The review covered the 40-year period from the 1978 Alma-Ata Declaration on primary health care to 2018. In addition to identifying achievements, challenges, lessons and best practices associated with primary health care generally until 2018, the review also aimed to make recommendations on the way forward in order to accelerate national, regional and global health strategies and plans for universal health coverage, primary health care and the Sustainable Development Goals. In order to offer this forward-looking direction, the review incorporated into its retrospective analysis an examination of whether and how primary health care efforts had helped to achieve universal health coverage and Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and its associated targets. Two practical guideposts helped to frame the review in this regard:

- **Role of primary health care in achieving universal health coverage.** The primary health care vision document set forth by WHO and UNICEF outlines the various pathways through which each of the main components of primary health care (that is, primary care and essential public health functions, multisectoral policy and action, and empowered people and communities) is envisioned as reinforcing universal health coverage in the three main ways in which it is enabled, namely by: (i) promoting financial protection/reducing household expenditure on health, (ii) quality services, medicines and vaccines, and (iii) equitable access. The review explicitly took stock of achievements and challenges along these specific pathways as a means of identifying best practices and lessons for the future. Two more recently published documents reiterate this link. WHO’s recent universal health coverage monitoring report for 2019 frames primary health care as the “programmatically engine for [universal health coverage] in most contexts”⁶ in a variety of ways: through its emphasis on community empowerment and social accountability, its multisectoral approach that recognizes the connection between health and other sectors, its focus on integrating separate services in a holistic manner, its emphasis on cost-effectiveness by bringing comprehensive health closer to communities and homes and its aim of equity to ensure coverage for all. This linkage was reaffirmed by Member States at the high-level meeting of the United Nations General Assembly on universal health coverage on 23 September 2019, referring to primary health care as “the cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals”.⁷
- **Role of primary health care in achieving the Sustainable Development Goals.** The review examined the conceptual intersection between the main features of primary health care/universal health coverage and the Sustainable Development Goals (especially Goal 3) since the 2030 Agenda for Sustainable Development commits countries to achieving universal health coverage by 2030. The specific elements of primary health care as a vehicle for universal health coverage that are mentioned in the 2030 Agenda include: financial risk

⁴ See document EB142/2018/REC/2, summary record of the eleventh meeting, section 2.

⁵ See documents EB144/51 and EB144/2019/REC/2, summary record of the fifteenth meeting, section 3.

⁶ Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report. World Health Organization; 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/, accessed 28 October 2019).

⁷ Political Declaration of the High-level Meeting on Universal Health Coverage: “Universal health coverage: moving together to build a healthier world” (<http://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>, accessed 28 October 2019).

protection; access to quality essential health care services; and access to safe, effective, quality and affordable essential medicines and vaccines for all. Moreover, as referenced above, the high-level meeting in September 2019 emphasized primary health care as being “the cornerstone” to achieving the health-related Sustainable Development Goals.

The review aimed to assess global progress towards primary health care implementation through two complementary information sources: a systematic review of existing published data sources and an assessment of country-level implementation through Member State engagement and inputs obtained by means of an online survey for all Member States. The **desk review** involved a review of reports from all six WHO regions and included a review and synthesis of high-level documents and country-level case-study reports. An **online Member State survey** was launched in the six official languages of the Organization on a secure WHO electronic platform. Ninety-four Member States provided focal points and a total of 50 responses were received.⁸

The overall process and methodological approach followed the principles set forth in the *WHO evaluation practice handbook*⁹ and the United Nations Evaluation Group *Norms and Standards for Evaluation and Ethical Guidelines for Evaluation*.¹⁰ The review also adhered to WHO cross-cutting evaluation strategies on gender, equity, vulnerable populations and human rights, and included, to the extent possible, disaggregated data and analysis. Data from the online survey and the desk review were cross-checked, verified and validated to ensure accuracy and consistency.

Key findings

Key findings from the desk review and online survey are summarized under the four evaluation questions:

(a) What have been the enabling factors and challenges in developing and implementing primary health care approaches in countries over the past 40 years?

The **key enabling factors** in developing and implementing primary health care approaches in the past 40 years that were cited in the review are as follows:

- i) *Political will and good governance*. Survey respondents highlighted the role played by ministry officials, politicians and other leading figures who are willing and able to advocate, pass legislation and implement health reforms that support primary health care. However, it was also noted that formal institutional arrangements such as ministerial councils set up to oversee primary health care help to ensure that gains are sustained beyond electoral cycles.
- ii) *Promotion of health reforms*. Reforms to reorient health care systems towards primary health care take time and often consolidate only after incremental changes over decades. These include various aspects of the health system such as universal health coverage-related legislation, increased financing and financial risk pooling, equity-promoting initiatives, health information systems and other uses of technology.
- iii) *Strengthening health systems towards primary health care*. This broad area includes ensuring community participation and intersectoral engagement.

⁸ Responses were received from 49 Member States and one territory.

⁹ WHO evaluation practice handbook. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/handle/10665/96311/9789241548687_eng.pdf;jsessionid=B9451D6A553A070BADE75ED7E874F623?sequence=1, accessed 29 October 2019).

¹⁰ Norms and Standards for Evaluation. New York: United Nations Evaluation Group; 2016 (<http://www.unevaluation.org/document/download/2787>) and UNEG Ethical Guidelines for Evaluation, United Nations Evaluation Group Foundation Document (UNEG/FN/ETH(2008); <http://www.unevaluation.org/document/detail/102>) (both accessed 29 October 2019).

- iv) *Increasing access to essential programmatic initiatives.* Examples of such initiatives include those for maternal and child care, nutrition, immunization, care and treatment of communicable and noncommunicable diseases and other essential elements of primary health care systems.
- v) *Partnerships.* These include engagement of government with civil society, nongovernmental organizations, community-based organizations and private sector entities.
- vi) *Organizational management.* This includes changes in health care organizational management, in particular, the establishment of family practices and/or multidisciplinary teams and the introduction of nationwide screening or preventive care measures.

Many of the **key challenges** identified in the review represent the inverse of the enabling factors described above. Others included the following:

- i) *Human resources for health.* The health workforce was reported as a key challenge in the online survey and also in the desk review, in particular, the distribution of health workers (urban/rural disparities) within countries, as well as the international recruitment of health care professionals and the phenomenon of brain drain. High staff turnover (resulting from attrition), the lack of incentives to encourage health workers to pursue professional development both for career progression and to maintain required skills and qualifications were also noted. The challenge of maintaining an adequately skilled workforce is particularly acute in remote and underserved areas.
- ii) *Limited financial resources.* This could be due to economic downturns or shifting political contexts, or to inefficient funding allocations resulting from an inappropriate bias towards secondary and tertiary care (which is more expensive). Primary health care often struggles to attract adequate funding in the face of demands from secondary and tertiary care. The reduction of public health budgets negatively affects vulnerable groups, as do users' fees and increases in out-of-pocket expenditures.
- iii) *Inadequate policy frameworks.* Poor coordination of policies across sectors and gaps in certain primary health care-related policies were cited as a significant challenge. Survey respondents identified having an unclear policy agenda as a challenge to the development and implementation of primary health care. Poor coordination of policies within government, coupled with poor coordination of policies between the government and other stakeholders, were mentioned as specific examples of these challenges. Some respondents also mentioned a gap in primary health care-related legislation in their respective countries.
- iv) *Poor quality of health services.* Even where universal and comprehensive coverage has been or will likely be achieved, timely access to quality health services was cited as a challenge. The desk review noted chronic shortages of qualified staff, equipment and supplies, coupled with an absence of basic standards in health care delivery or weak enforcement where such standards exist, which further exacerbate inequity of access to quality health care.
- v) *Health information systems.* Health information is crucial to enabling an understanding of the health needs of the population, for monitoring services and for undertaking evidence-based planning and decision-making in programming. Evidence-based decision-making is often constrained by challenges arising from poor quality of data, limited data availability and underuse of available data. The lack of interoperability among country-based information systems results in different entities collecting (and often duplicating) information that cannot be shared among national institutions.
- vi) *Context-specific challenges related to health inequities and access barriers.* Such challenges are faced by vulnerable groups such as women, socioeconomically disadvantaged populations, rural dwellers, refugees and internally displaced persons, ethnic minorities and other marginalized groups.

(b) How have primary health care and related innovations helped to improve health outcomes, equity, intersectoral collaboration and efficiency?

- i) *Improved health outcomes.* Survey respondents mentioned improved health in their populations as one of the key achievements in their implementation of primary health care, for example, progress in maternal health and child care, a decrease in communicable diseases, a high success rate in immunization coverage and control of vaccine-preventable diseases, and improved life expectancy. A smaller number of respondents cited the reduction in noncommunicable disease risk factors such as tobacco and alcohol use.
- ii) *Improvements in equity.* With respect to equity, human rights and the needs of vulnerable groups, policies and strategies have been developed that steer the global health community closer towards the goals set in the Alma-Ata and Astana Declarations, and the Millennium Development Goals and the Sustainable Development Goals. These gains included equity of geographic access to services (for example, between urban and rural/remote communities) and improved equity across socioeconomic groups in some countries.
- iii) *Devolved decision-making and enhanced accountability.* Devolved decision-making and enhanced accountability to subnational (for example, municipal or regional) levels of governments allowed integration of health and social care, improved coordination of services with secondary care and strengthened preventive activities. Health reforms in some countries' decentralized health care systems (from regional to local levels) reoriented primary health care towards families and communities.
- iv) *Empowering individuals and communities.* Through increased education, health promotion and communication, individuals, families and communities learn to take responsibility for their own health. Many countries now allow patients to choose their family doctor. Providing services to specific population groups such as refugees, elderly people or people with disabilities facilitates health access and improves health equity.
- v) *Innovations to improve primary health care performance and service delivery.* Initiatives such as public health insurance schemes and other financing mechanisms addressed socioeconomic disparities and made health care more accessible. Other innovations, such as performance-based payment schemes, improved primary health care in some countries, while the use of e-health systems improved networking and information sharing between medical disciplines and enhanced the quality of health care.
- vi) *Advances in information and communications technology.* This area included advances in telecommunications, the Internet, use of electronic medical records and development of e-health applications (telehealth, applications for mobile devices, e-referrals). Mobile applications and telemedicine have made working in remote areas, where many vulnerable, poor people live, more attractive for the health workforce in many locations. Technological resources have been used to augment the role of the health workforce and to provide training and education to develop a health workforce with the necessary knowledge and skills to effectively manage current and future health challenges.

(c) What intersectoral approaches have been implemented for primary health care?

- i) *Whole-of-society approach to health.* With primary health care representing a whole-of-society approach to health, the nature and extent of intersectoral collaboration is an important dimension of progress. The desk review unveiled a rich pool of intersectoral approaches that have been developed and implemented since 1978, ranging from intersectoral planning and implementation of multisector initiatives in rural community settings to implementation at national level.
- ii) *Health in All Policies approaches.* Several survey respondents mentioned adopting Health in All Policies approaches that encouraged government agencies to assess health impacts and take them into consideration in developing policy or legislation.

- iii) *Interministerial (horizontal) collaboration and coordination.* There are many examples of collaboration among various ministries (beyond the health ministries), for instance, collaboration between the ministries of health, education and agriculture for food and nutrition programmes in schools. The health and education sectors also collaborate to ensure that school health programmes include age-appropriate immunization requirements prior to school enrolment. Other examples of intersectoral action exist on a wide variety of topics including disaster preparedness and response, environmental health, road safety, water and sanitation, food safety, society-wide pandemic preparedness and measures to tackle noncommunicable diseases.
- iv) *Intergovernmental (vertical) collaboration and coordination.* This can take place between different levels of government (local, state and federal, for instance).
- v) *Collaboration and coordination between the Government and non-State actors.* This includes collaboration and coordination between the public and private sectors.
- vi) *Community level.* Several countries are aiming to improve social and health services by merging health sector agencies with those responsible for other social welfare services into a single entity, with a view to ensuring better coordination of funding and delivery. Some respondents report that this approach has great potential for strengthening coordination and integration of services, not least of all for particularly vulnerable groups such as older people, people with mental illness and people who abuse alcohol or drugs.
- vii) *Collaboration within the health sector.* The desk review showed that governments have also encouraged integrated care partnerships between voluntary and community representatives and service users in collaborative networks to respond innovatively to the needs of local communities. Intersectoral coordination among health sector entities involves closer working between the public and private sectors, engaging general practitioners, the family medicine system, laboratories, medical equipment and suppliers of medicines, and strengthening referral systems (vertical coordination between primary, secondary and tertiary care).

(d) What lessons and innovations from different country and regional technical or development contexts can be adapted and shared to promote and scale up future efforts in universal health coverage and primary health care?

- i) *Political will, good governance and leadership.* These are needed for primary health care to succeed, including through financial commitment for funding primary health care. Good governance is cited as being the foundation for achievement of primary health care goals, most generally by ensuring that coherent policies and strategies are in place to promote the health and well-being of the population in a people-centred manner.
- ii) *Primary health care promotes efficient use of financial resources for health.* The role of primary care in primary health care as a gatekeeping function prevents over-use of specialized care in secondary and tertiary services and reduces costs. The gatekeeping function depends on the quality and training of primary health care staff, as well as on well-tailored policies, functional referral systems and regulatory frameworks, which are essential to reduce health costs for health systems and patients. Enhancing accountability and transparency in the use of funds is important for Member States, as is predictable and sufficient funding for primary health care. Health insurance schemes and innovative public-private partnerships can also lead to improvements in health outcomes.
- iii) *A well-qualified health workforce is needed for successful primary health care implementation.* An effective primary health care system needs a skilled health workforce and interdisciplinary teams. Generating a health workforce that is adequate in terms of size and qualifications depends on the quality of health education and training, salary levels and regulatory frameworks. Equity of access and care depends on a sufficiently large health workforce that is sufficiently incentivized (financially or otherwise) to work in more remote or underserved populations.
- iv) *Community participation and engaged users improve access and quality of care.* Inclusive participation is essential to ensure that health systems remain people-centred and health

solutions are tailored to meet community needs. Engaging users of primary health care services with local policy-makers is important for a successful primary health care system. It is also important to ensure adequate regulatory frameworks and accountability mechanisms in health systems.

- v) *Evidence-based actions require improvements in collection and use of data.* In the desk review, data- and evidence-driven approaches were noted as key to effective and efficient primary health care implementation. For governments and other health sector staff to make well-informed decisions, the generation and use of data and evidence are crucial. However, government capacity to collect, analyse and use data is often subject to significant capacity constraints.

Conclusions and way forward

Global progress towards PHC implementation

As Member States noted in their positive overall self-assessment of their respective countries' progress since the Alma-Ata Declaration, the past 40 years have witnessed a number of significant achievements in the implementation of primary health care. Many health indicators have continued to improve in most countries and, on the whole, people are healthier and are living longer today than 40 years ago. Accordingly, numerous Member States focused on the end outcome of improvements in both the level and equity of health in their populations as one of the foremost achievements over the past four decades. As the review highlighted, various aspects of primary health care implementation were considered to have been instrumental in achieving these outcomes, with particularly significant progress in coverage of basic health care, immunization coverage and the eradication and control of a number of infectious diseases. In many countries, these achievements have been realized not only in the overall population, but rather also among subsegments of the population traditionally marginalized or particularly vulnerable for geographic and socioeconomic reasons; in so doing, these countries have made substantial progress toward the equity aims of primary health care.

Underpinning these accomplishments have been policy changes aimed to integrate the principles and goals of primary health care within countries' health systems. In some countries, these policy changes have led to targeted and incremental refinements of specific aspects of their existing health systems. In other countries, these changes have resulted in more fundamental reform of countries' health systems to bring them into line with the principles and goals of primary health care for equitable, effective, efficient and responsive health care. In numerous countries, these policy actions have translated into increased expenditure on health systems and specifically on primary health care-centred health systems.

One of the main elements of these reforms has been the move towards greater intersectoral collaboration. Such intersectoral approaches have encompassed, first and foremost, collaboration between ministries of health and various other ministries whose work is mutually reinforcing with the goals of the health sector. Importantly, they have included other levels of collaboration as well, for example: strengthened collaboration among the various health professions and disciplines; collaboration across various sectors of society (including civil society organizations, nongovernmental organizations and community-based organizations) and more generally between governments and non-State actors; and collaboration between and among separate levels of government and public administration (such as health authorities at the national, regional and local levels). This whole-of-government, whole-of-society, Health in All Policies approach constitutes an achievement in its own right for many countries.

This review emphasized that implementation of primary health care has not been a formulaic undertaking, but rather has been accomplished through a wide range of innovations that constitute a

subcategory of achievements themselves. The latter half of the post-Alma-Ata era has witnessed vast advances in information and communications technology that have revolutionized the delivery of primary health care. Innovations have come in less technology-related ways as well. For example, some have focused on improving service provision or enhancing the management of primary health care; others have comprised structural and administrative innovations to devolve decision-making to levels of government closer to the populations they serve; while others have focused on initiatives to empower communities and individuals themselves to take a more active role in their health. A range of other innovations have centred on strengthening the resourcing of health, in terms of both financial and human resources.

Although vast gains have been made in health outcomes over the past four decades, it is unclear to what extent these gains can be attributed directly to primary health care implementation. This information gap is unsurprising, as discussions surrounding the 2030 Agenda for Sustainable Development and Sustainable Development Goals have highlighted the gap in results-level data globally. That said, many Member States nonetheless maintain that implementation of primary health care has indeed contributed to overall improvement in health outcomes as well as equity.

In spite of the significant gains achieved globally in the implementation of primary health care, the review highlighted that such progress has been uneven both between and within countries, posing ongoing challenges to achieve equity. Beyond this overarching challenge, the review identified a wide range of areas that have frustrated efforts to achieve the goals of primary health care. Although there have been many noteworthy gains in some countries, the area of human resources for health has been a longstanding issue and remains an outstanding challenge in most countries' primary health care implementation efforts. Similarly, although most countries at all development stages have increased their funding to primary health care, health financing has remained inadequate, not least of all in light of increasing demand for health care, escalating health care costs and economic volatility. Despite vast advances in information and communications technology, those advances have not always been effectively taken up and used at scale to positively impact health and well-being and, in many countries, data have been of poor quality, limited or non-existent, or available but underutilized.

Another broad category of challenges revolves around the many facets of quality of care. At the broadest level, numerous Member States maintained that low quality of services, long waiting times and difficulties obtaining medical appointments represented some of their key challenges. In those Member States where primary care practitioners were involved as gatekeepers in order to reduce inappropriate demands on costly secondary and institutional care, referral processes did not always function as intended, contributing to fragmented or misdirected care. Elsewhere, especially in countries affected by conflict, poor health infrastructure is a significant factor that negatively affects quality of care.

At the highest level, one critical challenge highlighted in the review centres on the very intent of the Alma-Ata and Astana Declarations: the political will of governments to implement primary health care, including the related area of governance. Numerous Member States indicate that they still face challenges in generating and sustaining this political will. In other countries, political will might be present, but the policy context is inconducive to undertaking the ambitious changes necessary to implement primary health care: policy agendas, policy design, policy coherence and governance have often been inadequate, as has the regulatory framework for primary health care. In some countries, government engagement with non-State actors has been weak. In others, political instability or conflict have significantly hampered primary health care implementation efforts.

The review revealed a wide range of often interrelated factors that help to explain the range of achievements and challenges encountered over the past four decades. For example, political will is one of the key factors consistently cited as supporting primary health care implementation, while its

absence is seen as constituting a key challenge for many Member States. Conversely, financial protection measures are reported as positively affecting primary health care implementation as well as an achievement in many countries. Other key factors include: vibrant civil society organizations and the level of involvement of other non-State actors in a given country; the availability and effective distribution of skilled human resources for health; the degree of donor-driven intersectoral coordination; and the extent to which data- and evidence-driven approaches are used to implement primary health care.

However, the review revealed a much broader set of contextual factors that have affected primary health care implementation globally. Rapid globalization of the world economy has significantly shaped primary health care in a wide range of ways, some of these positive and others less positive. Broad demographic trends have resulted in older populations living longer lives, but not necessarily longer and healthier lives, and often without population replacement by economically active younger cohorts to adequately support increased longevity. Globally, the increasing burden of noncommunicable diseases, injuries and disabilities in relation to communicable diseases represents another key shift in the global context affecting the implementation of primary health care. Intrastate conflict, meanwhile, has placed a significant burden on those countries party to such conflicts – as well as those not party to the conflicts.

The way forward

The Astana Declaration takes a clear, forward-looking view of primary health care implementation, explicitly anchoring its vision for the future of such implementation in the 2030 Agenda for Sustainable Development and the Sustainable Development Goals. More recently, the linkage between primary health care, universal health coverage and the Sustainable Development Goals was reaffirmed by Member States at the high-level meeting of the United Nations General Assembly on universal health coverage on 23 September 2019. In the political declaration ensuing from this meeting, primary health care was considered to be “the cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals”.¹¹ The underlying lessons from this review could thus help inform the way forward.

Despite the wide range of experiences globally over the past 40 years, many of the lessons emanating from these experiences can be consolidated into a much smaller subset of guideposts moving forward. Framed as lesson statements, these include the following:

- **The translation of political will into action is a prerequisite for achieving the principles and objectives of primary health care.** In both the Alma-Ata and Astana Declarations, the international community committed itself to action on primary health care. As this review suggested, some countries have translated this commitment into a broad range of concrete policy actions, strategies and regulatory frameworks – as well as financial resources that are commensurate with their ambitious commitments. Other countries have seen less progress in translating their commitments into concrete action for various reasons. One lesson emerging from this review is that, in order for implementation to be effective in realizing the objectives and principles of primary health care, commitments require political will to be translated into concrete and consistent policy action, and resources.
- **Successful primary health care implementation calls for broad-based partnership.** The Astana Declaration in particular calls on governments, as well as the United Nations system (WHO, UNICEF and other international organizations) and non-State actors to work in

¹¹ Political Declaration of the High-level Meeting on Universal Health Coverage: “Universal health coverage: moving together to build a healthier world” (<http://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>, accessed 28 October 2019).

partnership towards the goals of primary health care. The extent and strength of such partnerships have varied considerably from one country to the next, however.

- **Intersectoral collaboration, a core component of primary health care implementation, requires concerted effort.** This review underlined that intersectoral collaboration is multifaceted, extending well beyond interministerial collaboration between the health sector and other sectors. Rather, intersectoral collaboration can be between and among health specializations, between various sectors of society (the broad-based partnerships described above) and between and among levels of government and public administration. This review suggested that promoting these various forms of collaboration has been challenging and requires commitment translated into action as described above.
- **Equity remains an ongoing challenge.** Overcoming inequities both within and between countries is a stated commitment in the Alma-Ata and Astana Declarations, and yet it remains a persistent challenge. Many countries have made great strides in their efforts to translate the commitment to health as a human right into concrete actions to ensure equity within their borders. Many others have made less progress. Inequities persist between countries as well, with some lacking the resources or capacity and others struggling to generate the domestic political will to achieve equity.
- **A sufficiently large and sufficiently qualified health workforce is necessary to attain the goals of primary health care.** Human resources for health – and specifically attracting, managing and retaining a suitably sizeable and suitably qualified health workforce – emerges as a consistent theme in the present review. Importantly, as the experience of numerous countries underlines, in order for the goals of primary health care to be realized, it is vital that the health workforce be trained not merely in the technical aspects of their respective professions, but rather also in the principles and objectives of primary health care.
- **Various aspects of primary health care implementation can be incentivized.** As numerous examples in this review indicated, the goals of primary health care need not always be dictated but can rather be prompted through various incentive modalities. A few such examples include the use of salary incentives to attract and retain the health workforce, financial incentives to reward achievement of desired outcomes in medical practices, incentives to foster intersectoral collaboration and incentives to foster innovation.
- **To develop and sustain primary health care systems in the future, continued innovation will be crucial.** Although it was not assumed in the review that innovation is inherently positive or always has exclusively positive outcomes, the review showcased numerous innovations that have helped countries to seize on opportunities and tackle challenges in primary health care implementation. These innovations are not limited to technology, but also entail creative solutions to help refine processes, reconfigure health finance approaches, restructure public administration and reform entire health systems to make them more people-centred, cost-efficient and equitable. In light of the continued challenges to primary health care implementation, coupled with the significant trends in the global context highlighted in this review (such as ongoing globalization, ageing populations, the shift of burden on health systems to noncommunicable diseases, and conflict in some countries), the need for innovative problem-solving will likely continue to grow.
- **Evidence-based approaches can help maximize success in primary health care implementation.** As the review revealed, some countries have actively sought to bring relevant evidence to bear on their primary health care-related decision-making processes,

while others have taken a less systematic approach. By learning from existing sources of knowledge, information, data and experience, countries can develop well-informed policies, programmes, strategies, regulatory frameworks, incentive structures and innovations based on what has worked (and what has not) rather than pursuing less evidence-based (and potentially less certain) options. The rapid development of information and communications technology in countries at all levels of development has served to facilitate the generation and sharing of knowledge, which can be key to accessing and using evidence.

With this broad overview of the achievements, challenges, enabling factors and lessons in hand, a number of areas for future action in the implementation of primary health care can be identified. Emanating from responses in the Member State survey, these recommendations can be categorized as follows.

Actions for governments

1. Strengthen, or continue to strengthen, the commitment to primary health care by translating this commitment into concrete actions (such as policies, strategies, regulatory frameworks, strengthened governance and broader reforms) through evidence-based approaches wherever possible.
2. Match this political will with financial commitment – in terms of both overall funding of primary health care-based approaches and specific measures – to improve financial protection of the population.
3. Undertake measures to ensure that human resources for health are adequate both in quantity and in quality – “quality” being grounded in primary health care principles and objectives as well as in technical expertise.
4. Enhance efficiency, seeking to achieve better value for money from existing health spending by streamlining service delivery, reducing waste and discouraging services without proven benefit.
5. Strengthen intersectoral collaboration within government by embedding whole-of-government, Health in All Policies approaches into policies, strategies, governance and incentive mechanisms.
6. Strengthen whole-of-society approaches through better engagement with nongovernmental actors such as communities, the private sector and other non-State actors.
7. Strengthen primary care services through further development and uptake of digital technologies, incentives for providers, establishment of organizations and relationships to foster more integrated service delivery and multiprofessional teamwork, more effective management of the interface between primary and secondary care (through gatekeeping and enhanced referral mechanisms through primary care) and an adequately trained health workforce.
8. Foster and support primary health care innovation as well as evidence-based approaches.

Actions for WHO and other actors¹²

23. Respondents proposed the following actions for WHO to be implemented in collaboration with relevant United Nations agencies, non-State actors and other partners:

1. WHO should continue to harness its convening role to foster intersectoral collaboration in the various forms described in the review, both at the global policy level and in individual countries in its support to governments.
2. In its normative role, WHO should continue to lead in the development of standards and policy and operational guidelines for the further implementation of primary health care pursuant to the commitments outlined in the Astana Declaration and, by extension, the 2030 Agenda for Sustainable Development and Sustainable Development Goals.
3. In its technical cooperation role, WHO should tailor its capacity-building efforts to the specific primary health care-related areas requiring further support identified in specific countries, for example, strategy development and implementation, health systems strengthening, Health in All Policies, health legislation, health financing, health technology assessment and management, human resources for health, community health approaches, research to improve service delivery, and monitoring and evaluation of primary health care implementation through support to voluntary national reviews.
4. In its advocacy role, WHO should identify and target the specific primary health care-related issues requiring such advocacy in individual countries, for example by advocating for increased health expenditure, identifying specific policy gaps requiring action and emphasizing the need for greater intersectoral collaboration and greater equity.
5. In fulfilling all these roles, WHO should enhance its support to evidence-based policy action, for instance by supporting systematic research and evidence generation to support policy-making in health, and documenting and disseminating lessons and best practices.

¹² In the Member State survey, respondents were asked to identify potential areas of action for WHO and other actors. However, the vast majority of responses revolved around the potential role of WHO moving forward.

1. Background

1. In the Alma-Ata Declaration of 1978, the signatory Member States to this seminal document “express[ed] the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world”.¹³ In so doing, they declared their commitment to the broad principles of primary health care (PHC): health as a human right that is the basis for economic and social development as well as world peace; health as not merely constituting the absence of disease or infirmity; health equity both between and within countries; and roles and responsibilities of governments for the health of their populations and of the people to participate in the planning and implementation of their health care. Setting a goal of “the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”, Member States placed PHC at the centre of this goal and articulated the core elements of PHC described elsewhere in this report. Member States underlined the need “to exercise political will, to mobilize [their respective countries’] resources and to use available external resources rationally”, and for WHO, UNICEF and other international organizations to support them in their efforts.

2. On the occasion of the fortieth anniversary of the Alma-Ata Declaration, participants at the Global Conference on Primary Health Care held in Astana, Kazakhstan on 25 and 26 October 2018 issued the Astana Declaration “reaffirming the commitments expressed in the ambitious and visionary Declaration of Alma-Ata of 1978 and the 2030 Agenda for Sustainable Development, in pursuit of Health for All”.¹⁴ In doing so, they committed to “make bold political choices for health across all sectors”, “build sustainable primary health care”, “empower individuals and communities” and “align stakeholder support to national policies, strategies and plans”, namely through knowledge and capacity-building, human resources for health, technology and financing.

3. Within this context, a review of 40 years of PHC implementation at country level was requested by the WHO Executive Board at its 142nd session in January 2018.¹⁵ The terms of reference for this review were presented to the 144th session of the Executive Board in January 2019 and were subsequently noted by the Board.¹⁶

4. Covering the 40-year period from the 1978 Alma-Ata Declaration on primary health care to 2018, the overall purpose of the review was to:

- (a) document global progress towards PHC implementation, identifying achievements and success stories, best practices and key challenges encountered; and
- (b) make recommendations on the way forward in order to accelerate national, regional and global health strategies and plans for universal health coverage (UHC)/PHC and the SDGs.

5. Although the concept of PHC has been operationalized in multiple ways over time and in different contexts, for the purposes of this review, the comprehensive definition articulated by WHO and UNICEF in their shared vision document for PHC provides the lens through which global progress, achievements and success stories, best practices and key challenges were identified in this review. This definition describes PHC as:

a whole-of-society approach to health that aims to ensure the highest possible level of health and well-being and their equitable distribution by focusing on people’s needs and preferences

¹³ Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 (https://www.who.int/publications/almaata_declaration_en.pdf, accessed 28 October 2019).

¹⁴ Declaration of Astana. Geneva: World Health Organization and the United Nations Children’s Fund (UNICEF); 2018 (WHO/HIS/SDS/2018.61; <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>, accessed 28 October 2019).

¹⁵ See document EB142/2018/REC/2, summary record of the eleventh meeting, section 2.

¹⁶ See documents EB144/51 and EB144/2019/REC/2, summary record of the fifteenth meeting, section 3.

(as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment.¹⁷

6. Nested within the overarching definition of PHC are three inter-related and synergistic components, namely:

1. **Meeting people's health needs** through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services;
2. Systematically **addressing the broader determinants of health** (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors; and
3. **Empowering individuals, families, and communities** to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-care sponsors and caregivers.¹⁸

7. In these ways, PHC is clearly differentiated from the closely related term "primary care", which is the organization of essential health services principally at the first level of care. As such, primary care is one important element of PHC, but is also clearly distinguished from the much broader concept of PHC as an overall approach to health.

8. As indicated above, the review, in addition to identifying achievements, challenges, lessons and best practices associated with PHC generally until 2018, also aimed to make recommendations on the way forward in order to accelerate national, regional and global health strategies and plans for UHC/PHC and the SDGs.¹⁹ In order to offer this forward-looking direction, the review incorporated into its retrospective analysis an examination of whether and how PHC efforts had helped to achieve UHC and SDG 3 (Ensure healthy lives and promote well-being for all at all ages) and its associated targets. Two practical guideposts helped to frame the review in this regard:

1. **Role of PHC in achieving UHC.** The PHC vision document set forth by WHO and UNICEF outlines the various pathways through which each of the main components of PHC (that is, primary care and essential public health functions, multisectoral policy and action, and empowered people and communities) is envisioned as reinforcing UHC in the three main ways in which it is enabled, namely by: (i) promoting financial protection/reducing household expenditure on health, (ii) quality services, medicines and vaccines, and (iii) equitable access.²⁰ The review explicitly took stock of achievements and challenges along these specific pathways as a means of identifying best practices and lessons for the future. Two more recently published documents reiterate this link. WHO's recent UHC monitoring report for 2019, , frames PHC as the "programmatically engine for UHC in most contexts"²¹ in a variety of ways: through its emphasis on community empowerment and social accountability, its multisectoral approach that recognizes the connection between health and other sectors, its focus on integrating separate services in a holistic manner, its

¹⁷ A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF); 2018 (WHO/HIS/SDS/2018.X; <https://www.who.int/docs/default-source/primary-health/vision.pdf>, accessed 28 October 2019).

¹⁸ Ibid., pp 2-4.

¹⁹ Ibid., pp 5-7.

²⁰ Ibid., pp. 6-7. The review will not systematically track progress against the 46 UHC-related indicators (or other indicators) enumerated in the [WHO Impact Framework](#), as this framework only takes effect in 2020.

²¹ Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report. World Health Organization; 2019 (https://www.who.int/healthinfo/universal_health_coverage/report/2019/en/, accessed 28 October 2019).

emphasis on cost-effectiveness by bringing comprehensive health closer to communities and homes and its aim of equity to ensure coverage for all. The linkage was reaffirmed by Member States at the high-level meeting of the United Nations General Assembly on universal health coverage on 23 September 2019, referring to PHC as “the cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals”.²²

2. **Role of PHC in achieving the SDGs.** The review examined the conceptual intersection between the main features of PHC/UHC and the SDGs (especially Goal 3), since the 2030 Agenda for Sustainable Development commits countries to achieving UHC by 2030. The specific elements of PHC as a vehicle for UHC that are mentioned in the 2030 Agenda include: financial risk protection; access to quality essential health care services; and access to safe, effective, quality and affordable essential medicines and vaccines for all.²³ Moreover, as referenced above, the high-level meeting in September 2019 emphasized PHC as being “the cornerstone” to achieving the health-related SDGs.

9. Moreover, in its PHC vision document WHO conceptualizes both UHC and SDG 3 as exerting a reciprocal, mutually reinforcing effect on PHC. However, since this relationship is less well developed in the vision document, and since the TOR for the review does not explicitly identify this reciprocal relationship as a line of inquiry, it was not included in the review.

10. Toward this end, the review aimed to address the following key questions:

- (a) What have been the enabling factors and challenges in developing and implementing PHC approaches in countries over the past 40 years?
- (b) How have PHC and related innovations helped to improve health outcomes, equity, intersectoral collaboration and efficiency?
- (c) What intersectoral approaches have been implemented for PHC?
- (d) What lessons and innovations from different country and regional technical/development contexts can be adapted and shared to promote and scale up future efforts in UHC/PHC?

²² Political Declaration of the High-level Meeting on Universal Health Coverage: “Universal health coverage: moving together to build a healthier world” (<http://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>, accessed 28 October 2019).”

²³ United Nations General Assembly resolution 70/1 (2015), Transforming our World: the 2030 Agenda for Sustainable Development (https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E accessed 5 November 2019).

2. Methodology

11. The review covered the 40-year period from the Alma-Ata Declaration on primary health care to 2018. It aimed to assess global progress towards PHC implementation through two complementary information sources:

- A desk review of existing published data sources using a data collection instrument developed to enable consistent, systematic data capture across all documents reviewed; and
- An assessment of country-level implementation through Member State engagement and inputs obtained by means of an online survey for all Member States.

12. The **desk review** involved a review of reports from all six WHO regions and included two levels of analyses, namely:

- a review and synthesis of 8 high-level documents, including 2 reports produced at the twentieth²⁴ and thirtieth²⁵ anniversaries of the Alma-Ata Declaration, respectively, and 6 reports produced at the regional level in preparation for the Global Conference on Primary Health Care in Astana, Kazakhstan in October 2018;²⁶ and
- a review and synthesis of 106 country-level case-study reports on the topic of PHC produced by five authoritative sources.²⁷

13. By means of a circular letter issued on 18 March 2019, Member States were invited to designate a focal point with first-hand experience of PHC implementation at country level to complete an **online Member State survey**.²⁸ This survey was launched in the six official languages of the Organization on a secure WHO electronic platform on 4 June 2019 and was available for 6 weeks with one reminder sent. Member States were also informed of the survey through a message from the Evaluation Office to the mission focal points based in Geneva. WHO Representatives were also encouraged to alert their national counterparts to this survey. Ninety-four Member States provided focal points and a total of 50 responses were received (49 Member States plus one WHO territory) - a response rate of 25%. Seventy percent of respondents were from the high-income or upper-middle-income categories. In terms of the regional representation of Member States, 34% of respondents were from the European Region, with 20%, 18% and 16% from the Regions of the Americas, the African and the Eastern Mediterranean Regions respectively. The South-East Asia and Western Pacific Regions each accounted for 6% of respondents.

²⁴ Primary health care 21: everybody's business. An international meeting to celebrate 20 years after Alma-Ata, Almaty, Kazakhstan, 27-28 November 1998. World Health Organization; 2000.

²⁵ World Health Report 2008: primary health care now more than ever. World Health Organization; 2008.

²⁶ *For the African Region*: primary health care programme in the WHO African Region from Alma-Ata to Ouagadougou and beyond. The Africa health transformation programme: a vision for universal health coverage. Contribution of the WHO Regional Office for Africa to the WHO global report; 2018. *For the Eastern Mediterranean Region*: Report on primary health care in the Eastern Mediterranean Region: review of progress over the last decade (2008–2018) (in draft). *For the European Region*: From Alma-Ata to Astana: primary health care – reflecting on the past, transforming for the future. Interim report from the WHO European Region. WHO Regional Office for Europe; 2018. *For the Region of the Americas*: Universal Health in the 21st Century: 40 years of Alma-Ata. Report of the high-level commission. Pan American Health Organization; 2019; and Primary health care at 40 years of Alma Ata. Situation in the Americas. Regional report. Pan American Health Organization; 2018. *For the South-East Asia Region*: Primary health care at forty: reflections from South-East Asia. WHO Regional Office for South-East Asia; 2018. *For the Western Pacific Region*: Primary health care in the Western Pacific Region: looking back and future directions. WHO Regional Office for the Western Pacific; 2018.

²⁷ These include: 18 reports produced in lead-up to the [Global Conference on Primary Health Care and the Declaration of Astana](#); 19 reports produced by the [Alliance for Health Policy and Systems Research \(AHPSR\)](#); 13 reports produced by the [Primary Health Care Performance Initiative \(PHCPI\)](#); 56 reports produced in conjunction with the [European Observatory Health System Reviews](#); and 12 reports produced by the [Organization for Economic Cooperation and Development](#).

²⁸ Member State survey available in Annex 2.

Table 1: Profile of respondents by World Bank country income group (2019)

Income group	F
High-income	23
Upper-middle-income	12
Lower-middle-income	8
Low-income	7
Total	50

Table 2: Profile of respondents by WHO region

WHO region	F
Africa	9
Region of the Americas ²⁹	10
Eastern Mediterranean	8
Europe	17
South-East Asia	3
Western Pacific	3
Total	50

14. The overall process and methodological approach followed the principles set forth in the *WHO evaluation practice handbook*³⁰ and the United Nations Evaluation Group *Norms and Standards for Evaluation* and *Ethical Guidelines for Evaluation*.³¹ The review also adhered to WHO cross-cutting evaluation strategies on gender, equity, vulnerable populations and human rights, and included, to the extent possible, disaggregated data and analysis. Open-ended (qualitative) data from both the online survey and the desk review were systematically coded. Data from the online survey and the desk review were then cross-checked, verified and validated to ensure accuracy and consistency.

Limitations

15. There is a substantial body of peer-reviewed academic literature as well as other literature, including several substantial reports produced by WHO, which describes PHC, discusses its implementation and assesses its impacts from various perspectives. It was not considered feasible or appropriate for the review to consider the entire body of published material. Consequently, it cannot be viewed as encompassing a comprehensive systematic review.

16. The Member State online survey was made available to all Member States and 50 responses were received. While those responses have provided valuable insights into many Member States' views and experiences, they cannot be taken to form a representative sample. Furthermore, the majority of questions sought to elicit open-ended, free text responses rather than relying on yes/no, multiple choice or rating scale formulations. Rigorous textual analysis was used to code responses, but it cannot be assumed that all Member States interpreted the questions in the same way or provided responses that are consistent in their level of detail. Thus, the fact that N per cent of Member States' responses reported a particular issue or characteristic should not be taken to suggest that issue or characteristic was absent in the other Member States (100-N%). It may merely reflect the fact that it was not explicitly mentioned in their responses.

²⁹ This includes a response from one WHO territory in this Region.

³⁰ WHO evaluation practice handbook. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/handle/10665/96311/9789241548687_eng.pdf;jsessionid=B9451D6A553A070BADE75ED7E874F623?sequence=1, accessed 29 October 2019)..

³¹ Norms and Standards for Evaluation. New York: United Nations Evaluation Group; 2016 (<http://www.unevaluation.org/document/download/2787>) and UNEG Ethical Guidelines for Evaluation, United Nations Evaluation Group Foundation Document (UNEG/FN/ETH(2008); <http://www.unevaluation.org/document/detail/102>) (both accessed 29 October 2019).

3. Findings

Findings from the Member State survey³²

Question 2: Based on the various aspects of PHC as described in the Alma-Ata Declaration, what have been the key elements of PHC in your country over the past 40 years?

17. Responses from Member States suggest that there are at least four groups of initiatives of the PHC movement over the past 40 years which are related to broader health reforms. These include the following:

- (a) *Health legislation-related initiatives.* These initiatives include legislative reforms and other policy mechanisms used by Member States such as: UHC-related legislation and health transformation programmes.
- (b) *Equity-related initiatives.* These include the promotion of engagement of the primary care sector to increase access to health care for underserved, marginalized and vulnerable populations and social health insurance schemes.
- (c) *Health system and its components.* These initiatives include governments' responsibilities for shifting health finance systems towards more PHC-conducive approaches, ensuring community participation and engagement, intersectoral coordination (including with other ministries beyond the health sector, as well as the private sector), engaging general practitioners (GPs), the family medicine system and strengthening referral systems. It also includes health information systems (HIS) and the use of technologies; and reforms in relation to the health workforce.

“While total per capita health spending has not increased proportionally with the growth of this country’s GDP, it has nevertheless increased from US\$ 102 in 2000 to US\$ 207 in 2013. In parallel, the financial barriers to health care seem to decrease: the percentage of women who reported problems accessing health care for reasons related to cost, for example, fell from 56% in 2008 to 42% in 2013.” (lower-middle-income country)

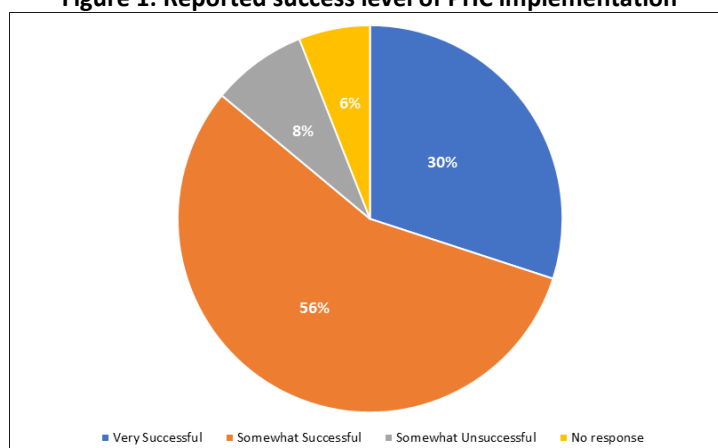
- (d) *Programmatic initiatives.* These initiatives include increasing access to services in various health programmes.

Question 3: How successful has the implementation of PHC been in your country overall?

18. About a third of Member State respondents reported that the implementation of PHC was “very successful” in their country’s own assessment, with over half reporting that it was “somewhat successful”. Some respondents reported that implementation of PHC in their country has been “somewhat unsuccessful”, while 3 did not respond to the question. Figure 1 illustrates these responses.

³² Member State survey available in Annex 2.

Figure 1: Reported success level of PHC implementation



19. As Table 3 below illustrates, this generally high success level was reported by countries at all developmental stages.

Table 3: Reported success level of PHC implementation, by World Bank developmental stage

Income group	Very successful	Somewhat successful	Somewhat unsuccessful	No response	Total
High-income	9	11	1	2	23
Upper-middle-income	3	5	3	1	12
Lower-middle-income	2	6	0	0	8
Low-income	1	6	0	0	7
Total	15	28	4	3	50

Question 4: What would you consider to be the key achievements in the implementation of PHC in your country?

20. The key achievements reported by Member States in the implementation of PHC in countries fell into four broad areas, namely: (a) access and quality enhancements; (b) policy changes; (c) improved health outcomes; and (d) equity gains.

- (a) *Access and quality enhancements.* Half of the respondents indicated that access to PHC services had improved. Specific aspects of improved access and quality cited included: (i) **financial protection**, with numerous Member States prioritizing this area through insurance or other means owing to its centrality to the goals of PHC (around a quarter of respondents noted this achievement, with some identifying increased public health expenditure more broadly); (ii) **infrastructure**, with improvements in the coverage or quality of infrastructure being reported by over a quarter of respondents as having contributed to better access to PHC; and (iii) **quality**, with some respondents noting improvements in quality, as measured by patient satisfaction and other means, as a key achievement.

“Reasonably good physical accessibility to an elaborate network of PHC centres. There are over 2 300 centres that provide good infrastructure, and reasonably equipped and staffed.” (high-income country)

- (b) *Policy changes.* A quarter of respondents reported moves to (re-)orient their health systems towards models more firmly rooted in family practices. Other policy changes cited by several

respondents included improvements to health care payment systems, changes in health workforce and technological enhancements such as introduction of e-health. An equally significant number of respondents mentioned the introduction of a “health in all policies” approach or enhanced intersectoral collaboration as key achievements.

“Autonomy was granted to PHC structures, including basic health facilities, which resulted in improvement for health workforce.” (low-income country)

- (c) *Improved health outcomes.* Numerous respondents focused on the end outcome of improved health in their populations as one of the key achievements in their implementation of PHC. For example, many respondents cited progress in maternal health and child care, and several respondents, mentioned a decrease in communicable diseases (CDs), increased immunization coverage and control of vaccine-preventable diseases as key successes. Some respondents cited improved life expectancy as an achievement of PHC and a few respondents cited the reduction in noncommunicable disease (NCD) risk factors such as tobacco and alcohol use as achievements.
- (d) *Equity gains.* Beyond improvements in the population as a whole, respondents explicitly pointed to equity gains, either in geographic or socio-economic terms, or both. Equity of geographic access to services (e.g. between urban and rural/remote communities) was cited as an achievement by several respondents while some reported improved equity across socio-economic groups.

Question 5: What have been the enabling factors in developing and implementing PHC approaches in your country?

21. Political will and governance, engagement with non-State actors (NSAs), availability of financial protection, integration of services, organizational management and service delivery, and HIS represent the main factors Member States reported as playing the greatest role in enabling implementation of PHC in their respective countries.

- (a) *Political will and governance.* Several respondents highlighted the significant role played by ministerial officials (up to and including prime ministers in some cases) and other senior political leaders in their country’s efforts to implement PHC. The most common indicator of political will as an enabler of PHC that was identified by most respondents was a sustained, incremental process of reform that extended over time and was not unduly affected by electoral cycles. A handful of respondents added that, while strong personal advocacy for PHC by influential individuals has been a significant driver of these efforts, more formalised institutional arrangements – such as ministerial councils established to oversee PHC – help ensure that PHC gains are more enduring. Several respondents cited the translation of this political will into increased funding for health care, and support for the health workforce through increases in staff numbers and investments in training, as providing further impetus to successful implementation of PHC.

“There has been a continued programme of investment in the primary care sector to build capacity and ensure appropriate staffing within primary care centres. In order to boost capacity and recruit additional therapy and nursing staff, substantial additional funding was provided in 2019 in comparison with 2018.” (high-income country)

- (b) *Engagement with NSAs.* Government engagement and collaboration with community-based organizations (CBOs), civil society organizations (CSOs), nongovernmental organizations (NGOs) and intergovernmental organisations) were cited by many respondents as key

factors affecting PHC implementation. Some respondents specifically cited national government engagement with donors and private-sector engagement as key factors.

- (c) *Financial protection.* Availability of financial protection, such as health insurance schemes, was highlighted by a number of high- and upper-middle-income country respondents not just as an achievement in its own right, but rather also as a key enabling factor facilitating PHC implementation.
- (d) *Integration of services.* Integration of services was identified by many respondents as an enabling factor that helped facilitate PHC implementation. Examples included the establishment of integrated ‘one-stop-shopping’ service providers and the introduction of ‘meso-level’ organisations that consolidate funding for services and re-shape delivery to be more responsive to local community needs.
- (e) *Organizational management and service delivery.* Several respondents, mostly from high-income countries, cited changes in organisational management as enablers of PHC implementation. The most commonly noted changes centred on the establishment of family practices and/or multi-disciplinary teams and the introduction of nationwide screening or preventive care measures.
- (f) *HIS.* Some respondents reported that use of HIS to support evidence-based decision-making had been an enabling factor in their development of PHC.

Question 6: What have been the greatest challenges in developing and implementing PHC approaches in your country?

22. Responses to this question were wide-ranging and focused on the health workforce, finance, health care costs, overall policy context, demand for PHC, quality of health services, and health information. In this vein, several of the areas cited as challenges by some respondents mirror what other respondents States cited as achievements and enabling factors.

- (a) *Health workforce.* Obstacles related to the health workforce were reported as a key challenge by most respondents. The most frequently cited specific challenges in this regard were the phenomenon of ‘brain drain’, high staff turnover and attrition as the result of retirement. Many respondents also reported challenges in maintaining an adequately skilled workforce that is able to deliver safe, quality care, and ensuring a balance between workforce availability in urban areas, on the one hand, and rural (and otherwise geographically remote) and underserved localities on the other. A lack of incentives to encourage health workers to gain or maintain required skills and qualifications was noted as a related health workforce challenge by some respondents.

“Low competence of GPs (in prescribing, in performance), which makes system ineffective and leads to useless referrals (represent our country’s greatest challenge).” (high-income country)

- (b) *Finance.* Many respondents reported that inadequate funding has been a significant challenge to their efforts to implement PHC. Health finance was portrayed by some respondents as being susceptible to economic fluctuations, consequential impacts on service users of high out-of-pocket (OOP) expenditures, and donor dependency.
- (c) *Health care costs.* Increasing health care costs generally, and the cost of training a qualified health workforce specifically, were reported by high-income and upper-middle-income country respondents in particular as the key challenges they face. Lack of affordability for the population, and, specifically, increasing OOP expenditures, were cited as related challenges.

"(Our government) introduced user fees during health sector reform in early 1990s, but still many couldn't afford the services; led to increased OOP payments." (low-income country)

"PHC faces very important challenges in terms of financing, existing capacity of both infrastructure and equipment and the health workforce and should focus on the priority and most vulnerable populations that have historically been excluded by the same system, as is the case of the indigenous population of our country. In this way PHC continues to meet its objectives in a universal way and guarantee the population an increasingly robust and consolidated health system." (upper-middle-income country)

- (d) *Overall policy context.* In contrast with almost two-thirds of respondents that cited aspects of political will as enablers of PHC, several respondents identified an unclear policy agenda or design as constituting a challenge to the development and implementation of PHC. As specific examples of this challenge, several respondents cited poor coordination of policies between government and other stakeholders and some cited poor coordination of policies within government, as well as political instability.
- (e) *Demand for PHC.* Some respondents highlighted the 'double burden' of CDs and NCDs, or the impacts of lifestyle-related risk factors, such as smoking, obesity and excessive alcohol consumption, on the demand for PHC. The identification of an ageing population as presenting challenges to PHC, poor levels of health literacy as increasing demand for PHC, and migration as a source of additional demand for PHC were also cited by some respondents.
- (f) *Quality of health services.* Low quality of health services, long waiting times, and difficulties in obtaining medical appointments represented some of the specific challenges cited in relation to the quality of health services. In addition, the clear delineation of roles and responsibilities between primary, secondary and tertiary care levels of health services, and the referral and gatekeeping function of PHC (through primary care) were reported as other key challenges.
- (g) *Health information.* Limited data availability, lack of adequate HIS and under-use of available data were some of the key challenges in relation to health information. Some respondents reported that under-use of available data presented a challenge, with only one respondent citing limited availability of data itself as a challenge in its own right – and none identifying poor quality of data as a challenge.

Question 7: What *intersectoral approaches* have been implemented for PHC in your country?

23. With PHC representing a 'whole-of-society' approach to health, the nature and extent of intersectoral collaboration is an important dimension of progress. More than three-quarters of respondents provided examples collaborative approaches being adopted in support of PHC. As shown in Table 4 below, these approaches encompassed collaboration among a wide range of stakeholders. Illustrative examples of such collaboration are provided in the passages that follow:

Table 4: Examples of collaboration in support of PHC cited by respondents

Collaboration between ...	Number of respondents citing
Health and other ministries	21
CSOs, NGOs, academia and the private sector	20
Health authorities at national, regional and local levels	10
Different health professions	7
Levels of the health system	7
Public/patient participation	7

- **Collaboration between health ministries and other ministries**
 - Low-income country: An HIV/AIDS prevention programme was implemented through a high-level intersectoral committee involving the Ministries of Agriculture, Education, Security, Social Work, Religious Affairs, Women’s Affairs, Finance, UN agencies, and donors.
 - Upper-middle-income country: Within the decentralized health services system, responsibility for primary care strengthening lies with the regional health authorities, which receive funding from local governments. A national steering committee on primary care strengthening brings together the two main stakeholder groups, the Ministry of Health and the regional authorities, to enhance policy coherence. The Ministry of Education promotes school-based health programmes and child protection with other relevant departments. Local government authorities are also engaged.
- **Collaboration between and among CSOs, NGOs, academia and the private sector:**
 - Upper-middle-income country: Universities led the assessment of health behaviour patterns in school children; and messages promoting intersectoral approaches to lifestyle changes as a way to improve health were consistently used in kindergartens, schools, primary care, and public health departments. NGOs promoted the principles of healthy parenting and educational activities through workshops, seminars, and conferences for parents and educators. Public and private centres were developed for long-term care, rehabilitation and palliative care of the elderly with dementia, post-stroke, and cancer.
 - Lower-middle-income country: Since January 2010, an intersectoral health commission, in which 43 public, private and nongovernmental institutions converge, coordinates intersectoral work to address health determinants.
- **Collaboration between and among health authorities at national, regional and local levels:**
 - High-income country: primary health networks, located across the country, provide the infrastructure to support, adjust and reform the PHC system within their respective regions. Specifically created to identify and address the gaps in PHC, these networks work collaboratively with other regional health stakeholders, such as local hospital networks and state and territory governments, to plan, design and commission evidence-based health services that support the specific needs of local communities and better integrate the health system at the local level.
- **Collaboration between and among individual health professions:**
 - High-income country: GPs are the gatekeepers between the primary care level and the specialized health care system. When necessary, assisted by diagnostic support from hospitals in the form of laboratory analyses, scans and X-rays, the GP refers patients to specialists, hospital care or health care services provided by the municipalities. This means

that the GP is responsible for ensuring that patients are offered the best possible and most appropriate treatment.

- **Collaboration between and among various levels of the health system (primary, secondary and tertiary):**
 - Upper-middle-income country: the national health system has implemented a system of referrals between PHC and other medical specialities that has led to more effective collaboration in the interest of patients.
- **Collaboration in the form of public/patient participation:**
 - Upper-middle-income country: A healthy environments and communities programme operates in municipalities, communities and the various environments where people grow, live, work and develop. The programme includes elements of PHC as integrated health prevention and promotion actions, in which the social determinants of health are identified, thereby contributing to the improvement of the health of the population in the communities through the promotion of healthy lifestyles.

Question 8: What important innovations have been introduced in the implementation of PHC in your country?

24. Innovations reported by Member States were mainly in the areas of: (a) information and communications technology (ICT); (b) overcoming geographical disparities; and (c) improved service provision, including quality of services.

- (a) *ICT*. Innovations in the fields of ICT centred on the use of electronic medical records to support improved collection and use of data for one-third of respondents. Several respondents cited the development of other e-health applications, such as apps for mobile devices which provide easy access to services or information, and e-referrals to facilitate transfers of patients within and between primary and secondary care services.
- (b) *Overcoming geographical disparities*. Some respondents cited measures used to help address geographical disparities which mirrored those noted in the areas of ICT. They encompassed innovative incentives designed to make work in remote areas more attractive, approaches using digitisation, apps for mobile devices to facilitate collection and use of data, and the introduction of telemedicine.
- (c) *Improved service provision*. Many respondents reported that they had introduced several innovative approaches to improve service provision. Networking and moves to facilitate data sharing among providers were most commonly cited. Some respondents also cited the introduction of incentives aimed specifically at improving quality of care, measures to encourage greater public engagement and self-care and the introduction of new services to respond to changing demands in areas such as care for the elderly.

Question 9: What if any effects has your country's implementation of PHC (including related innovations) had in your country more widely?

25. Respondents associated improved health outcomes and greater equity with implementation of PHC in the countries more widely:

- (a) *Improved health outcomes*. Many respondents reported that the implementation of PHC has contributed to overall improvement in health outcomes. Conversely, one high-income country reported that the lack of implementation of PHC has resulted in poor health

outcomes and one upper-middle-income country highlighted that the implementation of PHC has resulted in improved health outcomes at a lower cost.

- (b) *Increased access.* Several respondents reported that, following the implementation of PHC, access to health care in general had increased.
- (c) *Greater equity.* Several respondents representing various development levels reported that the gap in health status between socio-economic groups has been narrowed due to the implementation of PHC. Some of them also considered that PHC has enabled health service delivery to vulnerable populations.

Question 10: What lessons, best practices and innovations from your country's experience can be adapted and shared to promote and scale up future efforts elsewhere in the implementation of PHC – and the achievement of UHC, in line with SDG 3.8?

26. The Member State survey sought suggestions on lessons, best practices and innovations from countries' experience that could be adapted and shared to promote and scale up future efforts elsewhere in the implementation of PHC and the achievement of UHC.

Key Lessons

27. *Availability of trained health workforce.* Several respondents, largely representing low- and lower-middle-income countries, stressed the importance of having a qualified, trained and motivated workforce to deliver quality health services. Some of these further highlighted that it is not merely the size of the health workforce that is vital to PHC implementation, but rather also the quality of this workforce.

"The construction of health facilities, their equipment and the allocation of qualified personnel have improved the geographical accessibility of basic health care throughout the country to take account of equity." (lower-middle-income country)

28. *Political will, governance and leadership.* Respondents underlined that shared and sustained political vision and commitment are necessary "from top to bottom" - that is, at all levels of government - for the successful implementation of PHC. Incremental progress and capacity building within the government and in the public sector were further cited as key facets underpinning a government's ability to exercise political leadership in a positive manner.

29. *PHC as a gatekeeping function.* Several respondents referred to the gatekeeping function of PHC (through primary care), which enables patients to be directed to the appropriate level of care. Otherwise, greater importance would be given to curative rather than preventive actions.

Best practices

30. **Collaboration.** Many respondents reported engagement with local policy makers or with the users of services as key to success – specifically those that promote active community engagement and ownership of interventions by the community.

"The starting point is the right to health, a right that implies both rights and responsibilities of individuals, families and communities that use health services, as well as the obligation of the State to respect, protect and fulfil this right for all its citizens around the principles of availability, accessibility, acceptability, quality, warmth and humanity." (upper-middle-income country)

31. *Gatekeeping and referral.* The gatekeeping and referral role of PHC (through primary care) was also mentioned as a key best practice by several respondents.

32. *Evidence-based programme development.* Two upper-middle-income country respondents reported good practices in the area of evidence-based programme development, such as systematic, structured evidence-based prevention at the PHC level and evidence-based chronic care.

Innovations

33. *Financing models.* Many respondents reported the use of revolving funds, addressing socio-economic issues throughout a subsidized system, and some cited the provision of medicines/subsidies in order to reduce treatment costs of chronic diseases.

"Introducing adequate flexible financing mechanisms to support different priority strategies for payment of PHC services (a well-weighted capitation of 70-80% combined with a well-defined/prioritized fee-for-service of 10-20% and 10% rewarding special quality), and rewarding mechanisms for collaborative activities in the areas of home care, palliative care, rehabilitation services, midwifery and pharmacy (i.e. stop-smoking services, drug safety policy), etc." (upper-middle-income country)

34. *e-health and electronic health record-related innovations.* Several respondents reported key innovations in the area of e-health. Some of them introduced their newly-adopted technologies, such as: (a) the implementation of telemedicine projects, especially at the level of landlocked provinces; (b) an electronic medical records system; and (c) mobile app-based technologies.

35. *Innovative forms of integrated health action.* Several respondents reported innovative forms of integrated health action, such as coordinated patient-centred PHC services to ensure the continuum of care and interdisciplinary teams based in community health centres delivering both onsite and home-based outreach services.

"The mixed model of privately-owned businesses within a fully funded public health system is challenging and requires strong cross-government commitment to the development of innovative solutions." (high-income country)

36. *Innovative care for specific population groups* such as supporting home care, palliative care, integrated care for the disabled and respite and long-term care for the elderly were cited as important for countries with drastic demographic change.

Question 11: What key challenges do you see your country facing in its own efforts to fully implement PHC and achieve SDG 3.8 by 2030?

37. Key challenges identified by respondents focused on the health workforce, HIS, health financing, community participation, health care demand and access.

- (a) *Health workforce:* Many respondents cited the health workforce as a challenge. The vast majority of these respondents, mainly from low-income countries, specifically pointed to the issue of health workforce shortage. However, a few high-income countries also highlighted the potential threat of inadequate health workforce in the near future. A substantial number of respondents identified inadequate PHC skillsets as a key gap in efforts to fully implement PHC. A lack of "good governance" in domestic health systems, and regional inequalities in health workforce distribution are other key challenges highlighted by respondents.

"[identified challenges:] Lack of availability of specialized health professionals and lack of harmonization on the part of the institutions that regulate the higher-level academic training (particularly in terms of curricula and specialization) with the health needs of populations in remote areas." (upper-middle-income country)

"[Identified challenges:] Government's weak regulatory capacity – more focus on providing, rather than guaranteeing, health services; Rapid and unplanned urbanization coupled with weak implementation of PHC in urban settings; Weak health workforce management (production, recruitment, deployment, retention)." (low-income country)

- (b) *HIS*. Several respondents reported underdeveloped HIS as one of the key gaps. Linkages of information between health care levels impacting continuity of care are reported to be poor, and there is a clear lack of evidence-based planning. This lack of development of HIS is mainly attributed to very low budget allocation and limited investment in information and communications technology infrastructure in the health sector.
- (c) *Health financing*. Many respondents, mainly from low- and lower-middle-income countries, identified limited or unreliable financial resources as a key gap and several respondents reported lack of equitable distribution of health care resources as a gap. Additionally, the lack of sustainable financial protection mechanisms, inadequate health infrastructure, unsustainable and disrupted supplies of health commodities, and limited or unreliable public funding were some of the key challenges foreseen for the future, mainly by low- and lower-middle-income country respondents.
- (d) **Community participation**. Several respondents reported the lack of public/community participation in the health arena as a major concern for future work. The low priority assigned to patient- and community-centred care, insufficient involvement of the private sector, lack of transparency and accountability (including on the part of development partners as well as government) were cited by respondents as key challenges that Member States face.
- (e) *Health care demand and access*. Respondents cited demographic shifts, the increasing challenges posed by NCDs, and changes in disease patterns as having a potentially significant effect on demand for health care in the future. In addition, socio-economic inequities in access to health care and, even where universal and comprehensive coverage has been or will likely be achieved, timely access to quality health services throughout the country were cited as other major challenges that Member States continue to face.

Question 12: What efforts need to be undertaken in the future by governmental actors at the national and subnational level in your country so that PHC can be fully implemented and SDG 3.8 achieved by 2030?

38. Respondents mentioned several key actions that governmental actors at the national and subnational level should undertake in order to fully implement PHC and successfully achieve SDG 3.8 by 2030. These include the following overarching areas:

- (a) *Financial commitment and diversified funding*. A government's financial commitment to PHC was identified as being key to ensuring that PHC is fully implemented and SDG 3.8 is achieved. Some respondents specifically identified the need to diversify funding for PHC, such as instituting innovative mechanisms to mobilise additional resources, as one of the most important actions governments can take.

"Continued investment in blended funding models that encourage flexible and proactive team-based PHC services for those who would benefit and quality health outcomes." (high-income country)

"The country's health budget should be 6% of the national GDP, 30% of which should be dedicated to PHC". (upper-middle-income country)

- (b) *Efficient use of funding.* Along with government commitments for the financing of PHC, efficient use of this finance and other resources, through resource prioritisation and ensuring value for money, were also cited as being key to enhanced implementation of PHC and to the achievement of the desired results in the future. Over a quarter of respondents suggested improving the efficiency of the use of funding and resources. Some respondents highlighted the importance of enhancing accountability and transparency in the use of such funds.

"The Ministry of Public Health (MoPH) mainly has the stewardship role as the services via packages are implemented mainly by NGOs in the rural and deprived areas of the country. Having this important stewardship role, the MoPH has to put more emphasis on controlling the NGOs' expenses, and have strict control on the quality of their services." (low-income country)

- (c) *Improvement of financial protection for health.* Respondents cited the need to increase access to pooled funding and to reduce OOP expenses for health. Several respondents suggested that increased access to pooled funding and other forms of financial protection are key to ensuring that PHC is fully implemented and SDG 3.8 is achieved.
- (d) *PHC-related legislation and overall strategy development.* Policy direction in the form of legislative action and strategy development was cited by respondents as an important overarching area of action. Some respondents reported a gap in PHC-related legislation in their respective countries – particularly in the areas of family medicine, nursing, midwifery, community care, rehabilitation, palliative care and home care services. Nearly half of the respondents highlighted the importance of the government's role in developing PHC strategies.

"Legislation of the National Public Health Policy will be the key to human security in our country." (upper-middle-income country)

- (e) *Increasing leadership capacity.* This area was suggested by many respondents as a key government action for enhancing PHC implementation. Half of the respondents highlighted the significance of coordination and participation with other stakeholders and around one-third of respondents mentioned that internal managerial capacity within the government needs to be strengthened. In addition, several respondents highlighted the need to strengthen technical capacity within the government.

"Health sector governance – the roles and responsibilities need to be clearly segregated. The roles of different spheres of the government (federal, provincial, local) urgently need to be clarified and adequate structures to drive these functions need to be put in place." (low-income country)

Question 13: What specific role do you see WHO and other partners (e.g. NGOs, CBOs, civil society, the private and philanthropic sectors, other UN entities) playing in the future to support PHC implementation in your country?

39. Almost all respondents expressed expectations of WHO and other partners for the future. In particular, WHO's role as a "technical, normative and convening authority on health" was stressed by respondents. The following are some of the key roles expected of WHO and other partners to support PHC implementation:

- (a) *Convening role.* Many respondents expressed their expectation that WHO provide ongoing support for the coordination of all partners, including NSAs (with some specifically mentioning the private sector), NGOs and CSOs, for effective implementation of PHC moving forward. Some low- and lower-middle-income countries stressed the need for WHO to bring more financial resources to countries through this convening role, including convening partners for the development of joint programmes.

“Converging the efforts of all partners under the auspices of WHO through the development of joint programs/projects responding to national strategic priorities.”
(lower-middle-income country)

- (b) *Technical cooperation role.* Technical cooperation for strategy development and implementation, strengthening the health systems based on the six pillars - health in all policies, health financing, health legislation, health technology assessment and management, community health approaches, and research to improve service delivery - re some of the critical roles that the respondents expect WHO and other partners to play. In addition, a few respondents would also like to receive support for developing an evaluation framework and for evaluation of PHC implementation at the country level.
- (c) *Capacity-building.* Several respondents, especially from low- and lower-middle-income countries, stressed the need for the WHO and partners to support health systems capacity-building with a “long-term vision” in the following areas: (a) health workforce (training of health workers, including community health workers); (b) surveillance; (c) regulatory capacity; and (d) provision of diagnostic and logistic facilities at curative PHC facilities.
- (d) *Evidence-based policy and knowledge transfer.* Several respondents indicated that they expect WHO to lead systematic research and evidence generation to support policy-making in health, benchmarking of best practices, documenting and sharing best practices among Member States, and facilitating exchange of experiences between Member States.

“Based on the national experience, the collaboration with the European Observatory on Health Systems and Policies, which is hosted by the World Health Organization/Regional Office for Europe, was very successful in bridging the gap between policy-making and science and therefore supported evidence-informed decision-making.” (high-income country)

- (e) *Advocacy:* Respondents specifically cited advocacy with governments for increased expenditure on health as a percentage of GDP, for improved health equity, and for institutionalizing basic care, especially in low- and lower-middle-income countries, as some of the key roles that respondents expect of WHO and other partners. Other respondents cited advocacy for Health in All Policies and for specific health legislation on PHC. Some respondents from low- and lower-middle-income countries highlighted the need for advocacy with several stakeholders including donors, policy makers, academia, professional organizations and development partners, to strengthen PHC implementation capacities.

“Our health system is focused on PHC, but WHO could increase advocacy to put PHC on our country’s policy agendas and strengthen partnerships for PHC and its implementation. In addition, WHO could support PHC reforms in our country, mobilize more UN System agencies, bilateral and multilateral cooperation, and CSOs to support PHC.” (lower-middle-income country)

- (f) *Normative role:* Respondents expect WHO to continue to lead in the development of normative standards and policy and operational guidelines on PHC at the global level for the use of Member States.

“The World Health Organization should continue to be the world’s visionary leader for health. They describe what ‘should be’ while providing the evidence and guidance about how to get there. This includes sharing successful innovation, holding government’s accountable to ensure that primary care is able to play its leading role in ensuring health system sustainability and improving population health.” (high-income country)

Findings from desk review

40. The issues emerging from the desk review closely mirrored those reported in the Member State survey. This section provides an overview of the key takeaways from this line of analysis.

3.1. Progress in implementing PHC: key achievements

41. The documents reviewed portray a generally positive trajectory over the past 40 years. Numerous health indicators have continued to improve in most countries around the world and, on the whole, people are healthier and are living longer today than 40 years ago. Particularly significant progress has been achieved in coverage of basic health care; and improvements made in child health and immunization and the eradication and control of infectious diseases. Moreover, in response to the emergence of NCDs as a threat to health and an increasing burden on health systems, access to essential preventive and curative health services in this area has greatly improved in many parts of the world.

42. These documents suggest that actions taken by Member States and other actors to implement PHC have contributed to these achievements. Since the 1978 Alma-Ata Declaration, many governments have recognized that health is a fundamental, universal right of all, an essential condition for the integral and sustainable development of peoples, and a necessity for economic growth with equity. Accordingly, many governments have implemented fundamental reforms to their health systems through a wide range of policies and strategies to promote the vision of the Declaration of Alma-Ata for equitable, effective, efficient and responsive PHC, which in turn have underpinned the expansion of comprehensive UHC. These include, but are not limited to, the development national health strategies, essential medicines lists, regulatory frameworks in various aspects of health (e.g. the medical profession, medicines and medical equipment, patient privacy concerns, and so on). These policies and strategies commonly feature a comprehensive and holistic approach to health – for example, by not merely advancing agendas for improving Health for All through the life course, but rather also harnessing the health gains as the foundation for sustainable development. More recent documents explicitly frame this connection within the rubric of the SDGs.

43. In addition to health systems reforms, one major documented advance in respect of the goals of Alma-Ata – including the contribution of PHC to UHC – has been the increase in public health expenditure globally. Data collected and analysed since 2000 indicate this positive trend, showing per capita increase in public spending in all country income groups. However, this increase has varied greatly between and within income groups and indicates divergent spending patterns between richer and poorer countries. While high-income countries' per capita spending increased from an average of US\$ 1,357 in 2000 to US\$ 2,257 in 2016, upper-middle-income countries witnessed an increase from approximately US\$ 130 in 2000 to US\$ 270 in 2016. Similarly, in lower-middle-income countries, public spending on health per capita rose from US\$ 30 to US\$ 58 over the same period. In low-income countries, the spending on health per capita in real terms fluctuated considerably over the same period until, by 2016, public spending on health per capita was about US\$ 9 on average, only US\$ 2 higher than in 2000.³³

44. Part of the variation in countries' achievements (e.g. in terms of investment, OOP expenditure, integration of the public health and social security systems, coverage of the services, and health outcome indicators) is described as being attributed to divergent economic and social development trajectories. As one regional report points out, these differences can be associated with the historic evolution of the welfare state, which in turn is influenced by each country's particular economic, social, demographic and political variables. This increase has also varied over time as a result of the aforementioned economic fluctuations and, in some corners, the backsliding in progress is due to

³³ Public Spending on Health: a closer look at Global Trends., Geneva: World Health Organization; 2018, p. 13.

armed conflict and the associated strains of population migration and displacement. Overall, however, total health spending has grown faster than GDP globally, and even more so in low- and lower-middle-income countries (now close to 6% on average),³⁴ some of which devote more than half of public health spending on PHC.³⁵

45. Within this broader narrative of global achievements, best practices and success stories, the documents analysed also point to specific areas of achievement targeted in the present review – namely those related to innovation, intersectoral approaches, and the contribution of PHC gains to overall health outcomes, equity, intersectoral collaboration and efficiency.

3.1.1. Innovation

46. The documents reviewed pinpoint a wide spectrum of PHC-related innovations. Prominent among these are innovations in technological advances and in ICT, particularly over the latter part of the post-Alma-Ata era. For example, some ICTs have enabled people in remote and underserved areas to obtain access to services and expertise otherwise unavailable to them, especially in countries with uneven distribution or chronic shortages of physicians, nurses and health technicians or where access to facilities and expert advice requires travel over long distances. In such contexts, the goal of improved access to health care has stimulated the adoption of technology for remote diagnosis, monitoring and consultation. The internet is identified as a key enabling innovation in relation to these ICT gains, as are the “leapfrog” technologies that have enabled widespread telephone connectivity to all health facilities in many countries.

47. The specific innovations showcased in the analysed documents extend beyond the realm of technology, however. Based on the documents reviewed, these broadly fall into the following categories:

- **Innovations to devolve decision-making and enhance accountability to regional/municipal governments.** In one WHO region, for example, such devolution enabled better integration of health and social care in some countries, improved the coordination of services with secondary care in others, and strengthened preventive activities and enabled better alignment between services and the needs of local communities in yet other. More generally in these countries, devolution has helped to stimulate policy innovation, and contain health expenditures without widening health care inequalities, thus improving health outcomes. Similarly, in some countries in another WHO region, health reforms have sought to increase access by decentralizing to regional and local levels and reorienting PHC towards families and communities.
- **Innovations to enhance management of PHC.** Several (particularly high-income) countries have introduced innovations to enhance management of PHC providers in order to improve their performance and achieve better health system outcomes. Such innovations have revolved around strengthening business planning capacity, shifting roles and responsibilities between authorities and practitioners, contracting self-employed family doctors to extend service availability, and various changes in remuneration (including institution of performance-related payments aimed to enhance quality of care) and health insurance schemes.
- **Innovations to empower individuals and communities.** Numerous high-income countries have shifted to an administrative system that allows the patient to choose their family doctor. In one country, access barriers of refugee populations were reduced by facilitating their access to migrant health centres and providing services in their native language.

³⁴ Ibid., p. 1.

³⁵ Ibid.

- **Innovations to promote intersectoral collaboration.** These innovations constitute a broad and discrete area covered in the present review and are therefore addressed separately under “Intersectoral approaches” below.
- **Innovations in health finance.** These types of innovations have ranged from the introduction of social security and health insurance systems and basic benefit packages that enable all citizens to seek a basic level of care, across bundled payments for a collection of services to modalities whereby financial incentives are provided to GPs to improve their performance. Other financial innovations have been developed to specifically target poor and otherwise marginalized populations – for example, through subsidized and cross-subsidized systems (in which higher-income groups subsidize the health costs of lower-income groups) and revolving funds for medicines and medical supplies. In numerous countries, the establishment of health insurance schemes – through a wide range of financing models and with varying degrees of coverage and access-enhancing strategies – has succeeded in bringing UHC within reach and significantly increased protection from catastrophic financial expenditures, thus reducing a major barrier to health service access.
- **Innovations in the health workforce.** These innovations have centered on the generation and management of the health workforce in countries, and include: training and education to develop a health workforce with the necessary knowledge and skills to position PHC at the centre of health systems; delineation of the roles and responsibilities of the health workforce to effectively manage current and future health challenges; and the use of technological resources, especially information solutions, to augment the role of the health workforce.
- **Innovations in service delivery.** The number of countries using e-health systems to varying degrees (ranging from e-prescriptions to referral pathways) has grown dramatically, helping to strengthen service delivery through improved networking and information-sharing between and among various medical disciplines (as well as between technical sectors and social services) in a multi-disciplinary manner, thus enhancing efficiency and effectiveness in health care provision. This is particularly relevant in the management of long-term care and for the treatment of multiple morbidities, where several medical disciplines are required to collaborate effectively for the benefit of the patient.

In many of these areas, innovation has often taken place at the subnational level. At the same time, there has been a noteworthy trend among health ministries (as well as other areas of government) to establish innovation departments and to include innovation in their strategies and plans.

3.1.2. Intersectoral approaches

48. All of the key documents analysed for this review underscored the wide range of interpretations of this term and the need for greater understanding of what intersectoral approaches to health mean and how they might ideally be undertaken in countries. These reports suggest that optimal intersectoral collaboration consists of a “whole-of-government” and “whole-of-society” approach – for example, by identifying and concretely capitalizing on the linkages of agricultural, educational, environmental, fiscal, housing, transport and other policies and ensuring that health policies, strategies and interventions address health from this more holistic, integrated perspective. Importantly, this approach underlines the reciprocal relationship as well – i.e. working with other sectors to ensure that their respective policies, strategies and actions also incorporate a health approach wherever relevant. Juxtaposed against this model of collaboration, the reports analysed suggest that the tendency within the health sector has too often been to view collaboration as largely symbolic, one-sided and instrumental – that is, a model in which health-sector actors have sought to get other sectors to help health services (e.g. by mobilizing teachers to contribute to the distribution of bed nets). This limited conceptualization, they add, has constituted a significant obstacle to reaping the rewards of intersectoral action – not only by way of improved health outcomes, but also by way

of improved outcomes in non-health sectors and greater efficiency and multiplicative effectiveness between and among the various sectors.

49. Notwithstanding the identified need for a broader and clearer conceptualization of what optimal intersectoral collaboration means, the reports analysed for this review unveiled a rich pool of intersectoral approaches that have been developed and implemented since 1978. Examples range from intersectoral planning and implementation of multi-sector initiatives in rural community settings to implementation of Health in All Policies at national level to initiatives with a regional dimension, as illustrated in the following examples.

- **Intersectoral approaches at the community level.** Recognizing the reality that integrated programming of fully intersectoral engagement at the governmental level frequently requires fundamental, and often structural and cultural, changes in the way that government entities operate and in the way institutional incentives are designed, intersectoral approaches at this level are based on the notion that coordination and collaboration can often more readily be achieved at community level. Several countries are aiming at improving the coordination of social and health services by merging health boards and social welfare and services boards into a single entity, with a view to ensuring that social services and health services are both being organized and funded by municipal or regional levels of government. Some countries report that this approach has held great potential for strengthening coordination and integration of services, not least of all for particularly vulnerable groups such as older people, people with mental illness, and people who abuse alcohol or drugs.
- **Intersectoral approaches at the national level.** A number of reports analysed in the desk review describe the ways in which national governments have sought to strengthen a whole-of-government and whole-of-society approach. Traditionally, areas in which national governments have fostered intersectoral action include road safety, water and sanitation, food safety, pandemics and behavioural health (e.g. nutrition, smoking, sexually-transmitted diseases), through policies, strategies and guidelines to incentivize or mandate such intersectoral action. In some cases, national governments have also encouraged “bottom-up” approaches to intersectoral action through integrated care partnerships that bring together health and social service providers, voluntary and community representatives, and service users in collaborative networks to respond innovatively to the needs of local communities. In other countries where formal, permanent intersectoral structures do not exist, they have sought ad hoc intersectoral collaboration – e.g. through ad hoc interministerial working groups. A regional report illustrates how national governments can mainstream intersectoral work throughout their health system. It showcases the experience of a country in which a national government expressly pursued intersectoral coordination (alongside other policy choices, such as developing the health workforce) as a means of prolonging life expectancy, reducing child mortality, and achieving other targeted health outcomes – this despite significant economic difficulties. In this case, medical training was deliberately recalibrated to require medical professionals to understand the social determinants of health and, by extension, to shift their focus to preventive medicine as well as curative interventions. They were likewise required to work in multidisciplinary teams in comprehensive primary-care facilities, where they worked in close contact with their communities, social services and schools, key CSOs, and various governmental authorities. Importantly, these multidisciplinary teams were held jointly accountable for the health of the geographically-defined population under their collective care.
- **Intersectoral approaches at the global and regional level.** In 2003, 168 countries became signatories to the WHO Framework Convention on Tobacco Control in which they committed to taking coordinated, intersectoral actions to: implement increases in tobacco

prices through taxation; regulate packaging and labels; conduct educational campaigns; create advertisement bans; and support smoking cessation – including through regional mechanisms. Several examples from one WHO region demonstrate the possibilities that intersectoral collaboration at the regional level can pose in other areas, for example, integrating environment and health topics into transport policies.

3.1.3. Wider contribution of PHC gains

50. As a broad-based set of principles, PHC and its implementation have long been framed as having the potential to extensively influence health outcomes, improve equity, and help enhance efficiency in the delivery of health services. Another area assumed to benefit from PHC implementation is cost – i.e. by reducing the number of unnecessary consultations in secondary and tertiary health care institutions. In these scenarios, the gatekeeping function of PHC (through primary care), which rests on the quality and training of PHC staff as well as on well-tailored policies, functional referral systems and regulatory frameworks, is considered key to reducing health costs both for health systems and patients. Furthermore, by promoting better health for all, and greater equity in so doing, implementation of PHC is presumed to contribute to the realization of other human rights – e.g. through higher productivity, education, and so on.

51. Despite these presumed wider effects, none of documents analysed in the desk review explicitly address these. Rather, all suggest that PHC, when implemented meaningfully, is the optimal means of achieving these wider impacts, be these on the overall health of the community, health for all, the overall value for money of health interventions, or all of these.

52. With respect to the effect of PHC on **health outcomes**, the documents make clear that, while health outcomes have improved over the past four decades, not all of the success can be attributed to PHC alone. The last 40 years have seen significant reductions in poverty, increases in access to education, improved levels of literacy and other developments which have contributed to better health outcomes. (See the previous section on Intersectoral approaches.) At the same time, as mentioned already, the past 40 years have been marked by significant progress on a wide range of health outcomes. Some regions have surpassed SDG indicators (e.g. maternal mortality SDG Target 3.1 – *By 2030, reduce the global maternal mortality ration to less than 70 per 100 000 live births*).

53. With regard to **equity, human rights, and the needs of vulnerable populations**, a plethora of global, regional and national resolutions, policies and strategies have been developed that helped steer the global health community closer towards set goals in the Alma-Ata and Astana Declarations, and the Millennium Development Goals (MDGs) and SDGs – notwithstanding progress still to be realized in the area of UHC, the pledge to “Leave No One Behind” and “Health for All”, as well as specific SDG indicators such as the target for premature NCD mortality reduction by one-third by 2030.

54. **Efficiency** gains have also been made. As noted in the foregoing section, for example, technological advances and ICT have helped improve access, strengthen surveillance systems and facilitate more effective management of PHC services. Multidisciplinary teams, clear delineation between roles and responsibilities of primary, secondary and tertiary care levels and clear established referral pathways have contributed positively to the efficient use of health sector funding and more effective health service provision with the patient at the centre of the service provision.

3.2. Challenges in implementing PHC: key shortfalls

55. In spite of the significant gains achieved globally in the implementation of PHC, the documents analysed in this review reveal that such that progress has been uneven both between and within countries. These documents also reveal that PHC implementation has not been without its challenges. Some of these challenges have been rooted in the contextual factors that have shaped the environment in which PHC has been implemented (see “Global trends that have shaped implementation of PHC” below). In particular, globalization and its effects, the growing burden of

NCDs, and the changing nature of armed conflict have posed challenges in many countries to varying degrees. For example, various facets of globalization have made it difficult for some countries to provide adequate health finance in a sustainable manner, created population movements that have strained many health systems and that have resulted in inequitable access and outcomes in many countries. The growing prominence of NCDs, though accompanied by corresponding advances in the eradication and control of CDs, has created a double burden in other countries. The changing profile of armed conflict, meanwhile, has severely stressed the health systems of those States affected by conflict as well as the health of those directly exposed to conflict.

56. The specific challenges in implementing PHC extend beyond these contextual factors in the broad global landscape, however. The documents analysed in the present review highlight numerous such challenges. Much like the achievements described in the previous section, these challenges are often context-specific. The following subsections briefly summarize these challenges.

3.2.1. Access barriers

57. Equitable access is a dominant theme in most reports. Socio-economically disadvantaged populations, women, rural dwellers, ethnic minorities and other marginalized groups continue to be disadvantaged by health systems that fail to provide universal access. Despite significant improvements in financial protection for the general population in many countries, soaring OOP payments and informal costs continue to prevent less affluent segments of the population from seeking health care. Many countries have witnessed the phenomenon of inverse care, whereby people with the most means consume the most care, while those with least means and greatest health problems consume the least – supported by public spending on health services that most often benefits the rich more than the poor – in all country income groups alike. Urbanization and the concentration of specialist services in urban centres, has frequently been at the expense of access in rural areas. In many contexts, the sheer lack of service availability poses a major challenge in ensuring access: a chronic lack of staff, equipment and supplies, coupled with the absence of basic standards in health care delivery, further exacerbate inequity in access to quality health care for parts of the population. These persistent barriers to access continue to jeopardize the pledge to “Leave No One Behind” and provide UHC.

3.2.2. Health workforce

58. Many of the reports analysed for this review portray a global health workforce that is inadequate in number, in skills and in distribution to keep pace with needs in the face of emerging trends (e.g. changing epidemiological factors, ageing populations, the growing burden of NCDs and multiple-morbidity). In general, the generation of qualified health workers has been inadequate, leading to health workforce shortages in many countries. Some countries have been particularly negatively affected when qualified health workers have been drawn to more lucrative careers or countries, exacerbating these shortfalls in their countries (see “Globalization” below). Policies and incentives to enable better training, recruitment, deployment and retention of qualified personnel have been crucial in helping reverse this trend but have not always proved sufficient in doing so. Within this broader trend of under-resourcing, in some countries there is an over-supply of specialists, leaving a gap in the number of qualified nurses, GPs and family medicine practitioners and inflating health care costs with detrimental effect to equitable access. Conversely, in other countries there is a lack of specialists, which negatively affects the continuum of care.

59. Geographical equity largely depends on an even spread of health care professionals across a country. In this vein, rural areas have been particularly underserved in many countries, as numerous reports analysed in this review highlight. (Over half of the reports reviewed indicate an uneven spread between rural and urban health workforce availability.) The commercialization of health care has contributed to a depletion of the health workforce in rural and remote areas and the depletion of the health workforce in many countries has been exacerbated by the outmigration of health workers to more developed countries (see “Globalization” below). While multiple innovative approaches to

attract health professionals to work in rural areas have been developed, there is a persistent lack of qualified health workers in these areas.

3.2.3. Fragmented care

60. In some countries, the excessive specialization of health care providers and the narrow focus of many disease control programmes are considered to have hampered efforts to encourage a more holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care. While vertically implemented short-term projects, targeted to a specific health issue might require less resources and time than comprehensive, long-term programming, they lack sustainability and hamper long-term improvements in population health. Health services for poor and marginalized groups are often particularly fragmented as well as under-resourced with the persistent perception of limited revenue in sustainable, comprehensive PHC services for all. Humanitarian and development aid are still frequently contributing to this fragmentation.

3.2.4. Misdirected care

61. Resource allocation in many countries has continued to favour curative services, frequently at high cost, at secondary and tertiary care levels, while neglecting health care prevention and promotion – and PHC services which are often lower-cost approaches. With heavy emphasis on secondary and tertiary care services and patient's access to health care at any level (in the absence of effective gatekeeping through primary care), many countries are struggling to reduce the number of avoidable, often costly, hospital admissions.

62. The gatekeeping function of PHC (through primary care) is reported as a crucial means to moderate the use of specialist services and decongest overburdened secondary care facilities. It also positively impacts the effective use of health budgets, providing value for money, and furthers the provision of equitable services with socio-economic factors playing a major role in secondary care accessibility.

63. In this vein, health services, including referral systems, are not organized in a manner that ensures the continuum of care and efficient utilization of resources in many countries. Bypassing primary care directly to hospital services is a common problem, with outpatient services at major provincial referral hospitals often taking up primary care roles. Poor referral systems are combined with non-evidence-based practices, in particular the indiscriminate use of antibiotics and practices without therapeutic value, weak multisectoral action, inadequate focus on preventive and promotive services.

64. In the absence of gatekeeping – coupled with other factors, such as fee-for-service methods, public attitudes toward “doctor shopping” and a weak hospital infrastructure – health service provision was reported as being inefficient and inequitable in numerous countries analysed. In many contexts, outpatient services at major provincial referral hospitals often take up primary care roles further exacerbating the issue. However, this is also often needed in the absence of (or in light of the limitations in) PHC availability. Some country reports indicate that there is no clear delineation between primary and secondary care, and other country reports indicate the absence of any gatekeeping function enshrined in their PHC systems. In almost all contexts where gatekeeping is in place, there are exceptions to the rules for people to access secondary and specialist care directly thus furthering inequitable service provision for those who do not have the means to benefit from those “shortcuts.”

3.2.5. Unsafe care

65. In many countries, health systems are reported to have no minimum standards enshrined in their national health strategy, including basic safety and hygiene standards. This phenomenon has not only occurred both in low- and lower-middle-income countries, but rather also in upper-middle-income and high-income countries where regulation is low and minimum standards are not embedded in country health strategies – or where regulations and standards exist but are not properly monitored

and enforced. Consequently, essential health interventions – both in public and private health facilities – often do not meet the required quality and safety standards, resulting in high rates of hospital-acquired infections, medical errors, and other avoidable adverse effects that have been an underestimated cause of morbidity and mortality.

3.2.6. Insufficient, inequitable, and inefficient funding and lack of public resources

66. PHC financing is closely related to government commitment and recognition of the value-for-money aspect that PHC aims to achieve. However, insufficient, inequitable, and inefficient funding and lack of public resources are cited as persistent problems and constitute structural barriers in the progress toward universal health.

67. Public sector austerity measures associated with the global financial crisis have resulted in instances where public health budgets have been reducing, even in high-income countries, resulting in often very high OOP expenditures on health services for the general public. In many countries, revenues for PHC are stagnating or decreasing due to modest economic growth and decreasing donor funding, indicating how susceptible health systems are to economic fluctuations. Among the reports reviewed, only 18 countries have managed to diversify their funding to mitigate economic fluctuations and 22 countries report their sustained dependency on donors.

68. The growing commercialization of health care increases the risk of rent seeking (the practice of manipulating public policy or economic conditions as a strategy for increasing profits) at the expense of effective care. In one WHO region, health care budgets benefitted urban over rural areas for years. This may have been the result of more vocal urban dwellers, more politically powerful constituents, coupled with the fact that it is easier for governments to invest in select urban health care facilities (mostly hospitals, in the 1950s) than it is to invest in vast rural, geographically-dispersed, health posts. In many contexts, the focus on health finance remains on secondary and specialist care services with strong lobbies in the respective workforce, the private sector and the industry. Some countries, however, have recognized the benefit of investing in preventive and front-line services and turned their focus on building a robust PHC system.

3.2.7. Lack of scale-up of technological advances and innovations

69. Although the range of technological advances and innovations has been significant, multiple documents reviewed point out that these advances have not always been effectively taken up and used at scale to positively impact the health and well-being of individuals and populations. Much PHC-related innovation has had its beginnings in local, small-scale settings in which a number of dedicated individuals and teams have striven to improve conditions relevant to their immediate context. This has often meant a disconnect to national policy-makers, thus inhibiting systematic identification and analysis for wider use and subsequent national roll-out of such innovative approaches. Similarly, gaps are cited in the connection between academic innovations and their practical implementation unless financial gain is to be made. Costly technological advances often remain inaccessible to population groups that are not covered by insurance or other social safety nets, thus further aggravating equity issues in access to quality health care. In addition, inadequate policies and rigidities in health systems have sometimes resulted in the continued use of interventions with little or no benefit.

70. One specific area of particular challenge that has affected health care at all levels and in the majority of countries analysed has been in the collection and use of health information. In many of the documents analysed in this review, countries' health data systems are cited as insufficient, with the data being collected either being of poor quality, limited or non-existent, or available but underused. Lack of inter-operability among country-based information systems results in different entities collecting (and often duplicating) information that cannot be shared among national institutions. Health information is crucial, however, to enabling an understanding of the health needs of the population and for undertaking evidence-based planning and decision-making in programming. The lack of systematic health data collection and analysis has not only hampered the efficiency and

effectiveness of health programming, but rather also intersectoral collaboration, where data sharing is often vital for facilitating such collaboration and thus improving health outcomes and other sectoral determinants of health. Data sharing between sectors is cited as being particularly weak throughout the reviewed documents.

71. Evidence-based decision-making is more broadly constrained by limitations in data quantity and quality – and by the limitations in data analysis capacity of health authorities to produce, use, organize, and monitor health data. Districts are cited as being unable to effectively track progress towards the attainment of annual or longer-term goals as there is often inadequate data gathering and analysis for timely and effective decision-making due to the absence of real-time tracking systems. Another phenomenon is the fact that the management of HIS in some countries is donor-driven. As a consequence, data collected at the operational level are transmitted only to the donor at national level without necessarily copying the Ministry of Health, especially when these data are collected by community health workers paid directly by the CSOs without going through the health centre team. Closely related to the use of health information is the growing establishment and utilisation of e-health which has great potential to improve the systematic gathering of health data.

3.2.8. Decentralization of PHC

72. Many countries have embarked on a process to decentralize their health systems as a means of improving their responsiveness and performance. Between the four main categories of decentralisation (political, administrative, fiscal, and market decentralization), a wide range of degrees between centralized and decentralized health care systems are represented in the reports reviewed. One risk highlighted in association with the decentralization of the PHC system is the potentially growing inequity in geographical access to quality health care, with parts of a given country that benefit from stronger leadership and governance receiving better care than others. Some reports indicate that there is a tendency in a number of countries to reverse some of their decentralisation efforts towards specific features of health care being managed more centrally, often for reasons of fiscal constraints but also in trying to find the right balance to manage the growing health challenges and reaching UHC. Other reasons include the lack of institutional capacity at the local level to manage budgets and other key health system administrative and managerial functions.

73. There are numerous steps to be taken in decentralizing a health care system. Findings described in one regional report can be seen as representative of the potential shortfalls of incomplete transitioning to a decentralized PHC system: there is no institutionalization of the concept that PHC is the hub for coordinating all health services for well-defined communities within the district. Although decentralization has been implemented, certain aspects, such as financial and human resource management, have not been completely handed over to the lower levels. In addition, the technical, political and administrative capacity at the lower level does not match the level of authority transferred. As a result, the benefits of decentralization at district level are minimal in the absence of: adequate participatory planning and organization; effective communication with communities; effective management and coordination of programmes and services at all levels; and adequate intersectoral collaboration, particularly with the agricultural, education, water supply and waste disposal sectors.

3.2.9. Weak health infrastructure

74. Lack of infrastructure is often discussed in geographical terms in the documents reviewed, with more remote areas and areas with more scattered populations typically being more difficult to reach in an efficient and effective manner with an adequate health workforce and the housing, transport, equipment and supplies required to provide even a minimum standard of care. However, weak infrastructure is also discussed in the documents reviewed as including contexts where the health system developed towards a two-tiered system, in which a highly developed infrastructure is available to those who have the means while large parts of the community are unable to benefit. Especially in countries in which conflict has destroyed or greatly diminished existing health services,

the rebuilding of health infrastructure is a significant challenge. A number of countries have developed different approaches in overcoming their infrastructure challenges, including progressive roll-out strategies for comprehensive care packages, the establishment of minimum standards in PHC as building blocks for the establishment of a functioning health care system, and the re-allocation of financial and human resources to improve PHC coverage in underserved areas.

3.3. Key factors affecting PHC implementation

75. Some factors are global trends that have affected all or most countries. Other factors vary considerably from one country to the next.

3.3.1. Global trends that have shaped implementation of PHC

76. The eight high-level documents synthesized in the present review, produced at various junctures over the past 40 years, consistently emphasize that the core values conveyed in the Declaration of Alma-Ata – equity, solidarity and social justice – have remained salient to signatory States over four decades. This continuity of purpose, they emphasize, has prevailed despite a range of global trends which were not necessarily foreseen when the Declaration was agreed, and which have shaped the context in which PHC has been implemented.

77. This section briefly summarizes the four main shifts highlighted in the documents reviewed.³⁶

Globalization

78. The documents reviewed suggest that the rapid globalization of the world economy has affected the implementation of PHC in several ways. These effects include the increasing commercialization of health, in which private-sector actors have played an increasingly prominent role in the health sector in areas such as health insurance provision, pharmaceuticals, the development and provision of technology, medical education systems, and health care provision itself. In some countries, the growing influence of commercial actors has been accompanied by heightened political influence on institutional frameworks, governance and policy-making at the national and global levels as well. In an increasingly global economy, commercialization has also resulted in increased competition in these areas both within and across national borders.

79. An increasingly globalized, interdependent economy has resulted in greater economic volatility, with economic factors in one country having ripple effects across the globe. This economic volatility has often had direct effects on health finance and health systems generally, among many other areas of public expenditure. At a micro-economic level, it has also intensified the aforementioned commercialization and competitiveness in the health sector in many countries. At the population level, economic volatility has also had implications for equity, both between and within individual countries. The global economic crisis of 2008 is only the most recent example of this volatility. Earlier, in the 1980s, the debt crisis in the Region of the Americas led to austerity measures and a “lost decade” for health and development. In the 1990s, while the Region recuperated with a renewed emphasis on social safety nets, conditional cash transfers and health reforms emphasizing decentralization, the 1997 Asian financial crisis ensued. Here, as in the Americas in the 1980s, the International Monetary Fund enforced austerity measures which led to reduced public spending in affected Asian countries in exchange for loans to stabilize these troubled economies. In other cases where health systems were weakened by economic downturn or other causes, the private sector has

³⁶ Whereas other global trends highlighted in the Member State survey might well have influenced the global environment in which PHC has been implemented, these were not emphasized in the documents reviewed. These include: emerging threats to health, both generally and as a result of climate change and antimicrobial resistance; technological advances, perhaps most notably in the field of information and communication technologies, which have helped improve access, accelerated the creation and sharing of knowledge and ideas, strengthened surveillance systems; and supported better informed management of systems and resources; and increased focus on addressing the health needs of marginalized groups such as people living with HIV/AIDS, refugees and indigenous populations.

stepped in to fill vital gaps, but frequently with detrimental consequences for: equity of access for poor and marginalized population groups; attrition of the public-sector workforce to the private sector; and, when regulatory frameworks have been weak, for quality of service as well.

80. Globalization has also contributed to the long-standing trend of increasing urbanization across the globe. Rapid urbanization has led to an array of challenges in providing equitable health care both in sprawling urban settings as well as for correspondingly depopulating rural areas. The density that has accompanied urbanization has frequently brought with it substandard urban living conditions and significant socioeconomic disparities, which has frustrated efforts to eradicate and control CDs. At the same time, rapid shifts in lifestyle in some subpopulations – not least of all urban populations – has contributed to an increase in NCDs such as diabetes, heart conditions and obesity (see “Growing burden of noncommunicable diseases” below).

81. In fostering increasingly competitive global markets and greater mobility of labour, globalization also has a significant effect on the health workforce. With limited training and professional development opportunities, coupled with low salaries, in some countries, qualified health workers have left the public sector for more lucrative private-sector opportunities or higher-paying urban jobs in their own countries, thus leaving general gaps in the health workforce, specific rural gaps, or both. Others in these circumstances have increasingly sought opportunities across national borders. For the home countries these latter health workers leave behind, this attrition has often created or exacerbated significant workforce gaps in the health sector. At the same time, this trend has also increased the supply of qualified health workers in recipient countries.

82. Before this backdrop, and perhaps as a consequence of globalization and its effects, a proliferation of NSAs has emerged alongside the private sector. These actors have been comprised of CSOs and community-based groups that have advocated for the core principles expressed in the Alma-Ata Declaration – and for comprehensive care that is people-centred and responsive to their needs – in shaping health policies at national and subnational levels. This trend has occurred in tandem with a broader pattern of changing socio-cultural expectations in which an ever-growing number of citizens expect comprehensive care that is people-centred and responsive to their needs.

83. Finally, the documents reviewed emphasize that globalization has also affected the balance in the roles that international organizations, national governments, NSAs, local and regional authorities, and individual citizens have played in PHC implementation. The number and complexity of public health issues requiring coordinated global, national and subnational response has grown. For example, whereas profound advances have been made in the reduction of CDs, the growth in connectivity associated with globalization has entailed a heightened risk of pathogens spreading as a result of increased international travel. These include newly-emerging epidemics that spread quickly – across borders – and multiple-drug-resistant infections that have placed health systems under increasing pressure. These challenges have led to a need for increased coordination between and within affected countries where and when international health policies need translation into national guidelines and implementation – including with the growing number of NSAs, as the foregoing passages suggest.

Demographic changes

84. Numerous documents reviewed emphasize that successes in reducing child and maternal mortality, fatal childhood disease, and overall mortality throughout the life cycle have led to people living longer today than ever before. Combined with marked declines in fertility rates, these increases in life expectancy are leading to significant demographic changes globally. If these demographic trends continue, the increasing population of older people will require more resources to manage their health issues. At the same time, in many countries a decline in the population growth rate means that there will be fewer in the younger population to support the ageing population financially or otherwise.

Growing burden of noncommunicable diseases

85. The increasing burden of NCDs, injuries and disabilities represents another key shift in the global context affecting the implementation of PHC. Significant progress towards control and elimination of some CDs, such as polio, dracunculiasis and yaws, which previously placed considerable demands on health systems, has lowered the burden of these epidemiological sources of disease on populations – and on the health systems that address them. At the same time, the burden of NCDs has correspondingly grown, often resulting from changing lifestyles in tandem with improving income status in specific countries and populations. Such lifestyle changes include: dietary shifts toward more calorie-rich yet nutritionally-poor foods, more sedentary habits, increased tobacco and alcohol consumption, air pollution that often accompanies economic development, and more.

86. Though initially observed in high-income countries, this shift has become a global phenomenon. At the same time there are numerous countries, particularly low-income countries, which still face the challenge of CDs within their borders. Many of these countries face a double burden, struggling both to address the CDs that continue to strain their health systems as well as the NCDs that have formed an increasing share of their health challenges.

The changing nature of armed conflict

87. The last 40 years have witnessed a continuation of trend in the profile of conflict that had begun even prior to 1978. Whereas the overall incidence of inter-state conflict and armed struggles for independence in former colonies has continued to decline dramatically, the incidence of intra-state conflict (often with attacks targeting non-combatants and civilians) has risen. Those countries and regions where such conflict is prevalent have faced significant additional challenges in the health sector, with prior PHC advances being stalled or even reversed and considerable burden being placed on the already-strained health systems of countries hosting large refugee populations, internally displaced persons, or both – often for protracted periods.

88. Although the reviewed documents acknowledge that not all countries have been affected by these four shifts simultaneously or to the same degree, and that individual countries' specific social, epidemiological, economic, political, technological, demographic and environmental contexts vary considerably, they underscore that all four have played a central role in shaping the context in which PHC has been implemented over the past 40 years. In some ways and in most contexts, all have placed increasing strain on health systems, challenging countries to devise new ways of approaching PHC in the form of reforms, restructuring processes, collaboration and other means. In other contexts, they are portrayed as presenting opportunities as well (see "Other factors that have shaped implementation of PHC" below).

3.3.2. Other factors that have shaped implementation of PHC

89. Aside from these four global trends that have affected the success of PHC implementation, a number of other factors are cited that speak to internal factors in many countries that have affected their ability to fully realize the goals of PHC. These include the following:

- **Political stability and political will (including sound governance), translated into financial commitment.** As noted above, a number of documents analysed reveal that when political instability devolves into intra-state conflict, this phenomenon can strain affected governments' (as well as other actors') ability to fulfil the principles of PHC. Even in countries not directly affected by conflict, however, political stability – and political will more generally, the very impetus underlying the Alma-Ata and Astana Declarations in the first instance – is cited in the majority of documents reviewed as being a chief factor influencing countries' ability to successfully implement PHC. One key facet of political will cited in these documents is good governance, both generally and in the health sector specifically. Good governance is cited as being the foundation for the achievement of the goals of PHC in numerous ways, most generally by: ensuring that coherent policies and strategies are in

place that promote the health and well-being of the population in a people-centred manner; ensuring integrated, intersectoral, whole-of-government approaches; ensuring adequate vertical linkages among various levels of government, not least of all in decentralized health systems; forging and sustaining relationships between health services and the population served, and ensuring accountability of health systems to the population; establishing, monitoring and enforcing adequate and appropriate regulatory frameworks for all aspects of health systems; and ensuring equity, e.g. through social protection mechanisms that enable the reduction of OOP expenditure and thus enable people to overcome common access barriers. With health finance being a pillar of successful PHC implementation, numerous documents underline that political will specifically translated into sufficient financial commitment, is a closely-related factor affecting PHC implementation.

- **Donor-driven intersectoral coordination.** In countries that rely on donor support to finance their health systems, the role of donors in ensuring the integrated, intersectoral, whole-of-government approaches emblematic of PHC is cited as a major factor affecting the extent to which PHC implementation has been successful. In this vein, several reports emphasize that donor decisions – i.e. whether to fund narrowly within the health sector only or more broadly across the various sectors that have a role in health promotion, and whether and how to incentivize governments to pursue whole-of-government and whole-of-society approaches – play a central role in determining the success of PHC implementation efforts in many countries.
- **Strength and engagement of civil society and other NSAs.** Within the context of the proliferation of NSAs described above, the success of PHC implementation is cited in numerous documents analysed as hinging on positive engagement between government and these other actors. Such positive engagement can include the deliberate advancement of public-private partnerships on various health issues, including civil society and industry in major reform efforts, and other means of engagement. More broadly, the overall strength of civil society is viewed as a major determining factor in its own right, namely by ensuring that health systems remain people-centred, whether in ensuring health solutions are tailored to their needs, ensuring adequate regulatory frameworks and accountability mechanisms in health systems, or by influencing government to sustain the political will described above.
- **Availability and effective distribution of skilled health workforce.** Quality, people-centred, integrated care is cited in numerous reports as hinging on the quality of the health workforce in many countries. Moreover, equity of access and care depends on a sufficiently large health workforce that is sufficiently incentivized (financially or otherwise) to work in more remote or underserved populations. In this vein, the global health workforce shortage cited above has been a significant factor hindering full implementation of PHC. Generating a health workforce that is sufficient in size and qualifications, in turn, depends on the quality of health training, salary levels and regulatory frameworks.
- **Data- and evidence-driven approaches to PHC implementation.** In order for governments and other actors in the health arena to make well-informed decisions in any aspect of PHC implementation, the generation and use of data and evidence is cited as being crucial. The potential areas in which data and evidence can drive decisions are vast, but include: the development of policies and strategies that are based on the state-of-the-art knowledge on what works; analyzing and acting on overall population statistics as well as subpopulation statistics (not least of all for the advancement of equity); ensuring sustainability of health systems and cost containment, as well as analysing the cost implications of various approaches (e.g. prevention- versus treatment-based models); and the identification of lessons (both from within a given country and from other countries) as the basis of learning

and systems improvement. As mentioned previously, however, government capacity to collect, analyse and use data is often subject to significant capacity constraints.



Summary of key findings

90. Key findings from the desk review and online survey are summarized under the four evaluation questions:

(a) **What have been the enabling factors and challenges in developing and implementing PHC approaches in countries over the past 40 years?**

Responses to the Member State survey and the desk review suggest that actions taken by Member States and other actors to implement PHC following the 1978 Declaration of Alma-Ata contributed to improvements in health indicators. People are healthier and are living longer today than 40 years ago. Significant progress was achieved in child health, maternal mortality, immunization and in the eradication and control of infectious diseases (that is, the basic elements of a PHC system mentioned in the Declaration of Alma-Ata).

The **key enabling factors** in developing and implementing PHC approaches in the past 40 years that were cited in the review are as follows:

- i) *Political will and good governance.* Survey respondents highlighted the role played by ministry officials, politicians and other leading figures who are willing and able to advocate, pass legislation and implement health reforms that support PHC. However, it was also noted that formal institutional arrangements such as ministerial councils set up to oversee PHC help to ensure that gains are sustained beyond electoral cycles.
- ii) *Promotion of health reforms.* Reforms to re-orient health care systems towards PHC take time and often consolidate only after incremental changes over decades. These include various aspects of the health system such as UHC-related legislation, increased financing and financial risk pooling, equity-promoting initiatives, HIS and other uses of technology.
- iii) *Strengthening health systems towards PHC.* This broad area includes ensuring community participation and intersectoral engagement.
- iv) *Increasing access to essential programmatic initiatives.* Examples of such initiatives include those for maternal and child care, nutrition, immunization, care and treatment of CDs and NCDs and other essential elements of PHC systems.
- v) *Partnerships.* These include engagement of government with civil society, NGOs, CBOs, private sector entities and others.
- vi) *Organizational management.* This includes changes in health care organizational management, in particular, the establishment of family practices and/or multi-disciplinary teams and the introduction of nationwide screening or preventive care measures.

Many of the **key challenges** identified in the review represent the inverse of the enabling factors described above. Others included the following:

- i) *Human resources for health.* The health workforce was reported as a key challenge in the online survey and also in the desk review, in particular, the distribution of health workers (urban/rural disparities), within countries, as well as the international recruitment of health care professionals and the phenomenon of brain drain. High staff turnover (resulting from attrition), the lack of incentives to encourage health workers to pursue professional development both for career progression and to maintain required skills and qualifications were also noted. The challenge of maintaining an adequately skilled workforce is particularly acute in remote and underserved areas.
- ii) *Limited financial resources.* This could be due to economic downturns or shifting political contexts, or to inefficient funding allocations resulting from an inappropriate bias towards secondary and tertiary care (which is more expensive). PHC often struggles to attract

adequate funding in the face of demands from secondary and tertiary care. The reduction of public health budgets negatively affects vulnerable groups as do users' fees and increases in OOP expenditures.

- iii) *Inadequate policy frameworks.* Poor coordination of policies across sectors and gaps in certain PHC-related policies were cited as a significant challenge. Survey respondents identified having an unclear policy agenda as a challenge to the development and implementation of PHC. Poor coordination of policies within government coupled with poor coordination of policies between the government and other stakeholders were mentioned as specific examples of these challenges. Some respondents also mentioned a gap in PHC-related legislation in their respective countries (e.g. in the areas of family medicine, nursing, midwifery, community care, rehabilitation, palliative care and home care services).
- iv) *Poor quality of health services.* Even where universal and comprehensive coverage has been or will likely be achieved, timely access to quality health services was cited as a challenge. The desk review noted chronic shortages of qualified staff, equipment and supplies, coupled with an absence of basic standards in health care delivery or weak enforcement where such standards exist, which further exacerbate inequity of access to quality health care.
- v) *HIS.* Health information is crucial to enabling an understanding of the health needs of the population, for monitoring services and for undertaking evidence-based planning and decision-making in programming. Evidence-based decision-making is often constrained by challenges arising from poor quality of data, limited data availability and underuse of available data. The lack of inter-operability among country-based information systems results in different entities collecting (and often duplicating) information that cannot be shared among national institutions.
- vi) *Context-specific challenges related to health inequities and access barriers.* Such challenges are faced by vulnerable groups such as women, socio-economically disadvantaged populations, rural dwellers, refugees and internally displaced persons, ethnic minorities and other marginalized groups.

(b) How have PHC and related innovations helped to improve health outcomes, equity, intersectoral collaboration and efficiency?

- i) *Improved health outcomes.* Survey respondents mentioned improved health in their populations as one of the key achievements in their implementation of PHC, for example, progress in maternal health and child care, a decrease in CDs and a high success rate in immunization coverage and control of vaccine-preventable diseases, and improved life expectancy. A smaller number of respondents cited the reduction in NCD risk factors such as tobacco and alcohol use.
- ii) *Improvements in equity.* With respect to equity, human rights and the needs of vulnerable groups, policies and strategies have been developed that steer the global health community closer towards the goals set in the Alma-Ata and Astana Declarations, and the MDGs and the SDGs. These gains included equity of geographic access to services (for example, between urban and rural/remote communities) and improved equity across socio-economic groups in some countries.
- iii) *Devolved decision-making and enhanced accountability.* Devolved decision-making and enhanced accountability to subnational (for example, municipal or regional) levels of governments allowed integration of health and social care, improved coordination of services with secondary care, and strengthened preventive activities. Health reforms in some countries' decentralized health care systems (from regional to local levels) reoriented PHC towards families and communities.

- iv) *Empowering individuals and communities.* Through increased education, health promotion and communication, individuals, families and communities learn to take responsibility for their own health. Many countries now allow patients to choose their family doctor. Providing services to specific population groups, such as refugees, elderly people or people with disabilities facilitates health access and improves health equity.
- v) *Innovations to improve PHC performance and service delivery.* Initiatives such as public health insurance schemes and other financing mechanisms addressed socio-economic disparities and made health care more accessible. Other innovations, such as performance-based payment schemes, improved PHC in some countries, while the use of e-health systems improved networking and information sharing between medical disciplines and enhanced the quality of health care.
- vi) *Advances in ICT.* This area included advances in telecommunications, the Internet, use of electronic medical records and development of e-health applications (tele-health, applications for mobile devices, e-referrals). Mobile applications and telemedicine have made working in remote areas where many vulnerable, poor people live, more attractive for the health workforce in many locations. Technological resources have been used to augment the role of the health workforce and to provide training and education to develop a health workforce with the necessary knowledge and skills to effectively manage current and future health challenges.

(c) What intersectoral approaches have been implemented for PHC?

- i) *Whole-of-society approach to health.* With PHC representing a whole-of-society approach to health, the nature and extent of intersectoral collaboration is an important dimension of progress. The desk review unveiled a rich pool of intersectoral approaches that have been developed and implemented since 1978, ranging from intersectoral planning and implementation of multi-sector initiatives in rural community settings to implementation at national level.
- ii) *Health in All Policies approaches.* Several survey respondents mentioned adopting Health in All Policies approaches that encouraged government agencies to assess health impacts and take them into consideration in developing policy or legislation.³⁷
- iii) *Interministerial (horizontal) collaboration and coordination.* There are many examples from survey respondents and from the desk review that show collaboration among various ministries (beyond the health ministries), for instance, collaboration between the ministries of health, education and agriculture for food and nutrition programmes in schools. The health and education sectors also collaborate to ensure that school health programmes include age-appropriate immunization requirements prior to school enrolment. Other examples of intersectoral action exist on a wide variety of topics including disaster preparedness and response, environmental health, road safety, water and sanitation, food safety, society-wide pandemic preparedness and measures to tackle NCDs.
- iv) *Intergovernmental (vertical) collaboration and coordination.* This can take place between different levels of government (local, state and federal, for instance).
- v) *Collaboration and coordination between the Government and NSAs.* This includes collaboration and coordination between the public and private sectors.

³⁷ World Health Report 2008: Primary health care now more than ever. World Health Organization, 2008. As noted in this report, such approaches should not simply "start from a specific health problem and look at how other sectors can contribute to solving [it]" but rather looks at other sectors' plans and policies in order to determine what impacts they might have on health. It is not clear from the evidence available to what extent the latter is routine practice within current implementations of Health in All Policies.

- vi) *Community level.* Several countries are aiming to improve social and health services by merging health sector agencies with those responsible for other social welfare services into a single entity, with a view to ensuring better coordination of funding and delivery. Some respondents report that this approach has great potential for strengthening coordination and integration of services, not least of all for particularly vulnerable groups such as older people, people with mental illness and people who abuse alcohol or drugs.
 - vii) *Collaboration within the health sector.* The desk review showed that governments have also encouraged integrated care partnerships between voluntary and community representatives, and service users in collaborative networks to respond innovatively to the needs of local communities. Intersectoral coordination among health sector entities involves closer working between the public and private sectors, engaging GPs, the family medicine system, laboratories, medical equipment and suppliers of medicines, and strengthening referral systems (vertical coordination between primary, secondary and tertiary care).
- (d) **What lessons and innovations from different country and regional technical or development contexts can be adapted and shared to promote and scale up future efforts in UHC/PHC?**
- i) *Political will, good governance and leadership.* These are needed for PHC to succeed, including through financial commitment for funding PHC. Good governance is cited as being the foundation for achievement of PHC goals, most generally by ensuring that coherent policies and strategies are in place to promote the health and well-being of the population in a people-centred manner.
 - ii) *PHC promotes efficient use of financial resources for health.* The role of primary care in PHC as a gatekeeping function prevents over-use of specialized care in secondary and tertiary services and reduces costs. The gatekeeping function depends on the quality and training of PHC staff, as well as, on well-tailored policies, functional referral systems and regulatory frameworks, which are essential to reduce health costs for health systems and patients. Enhancing accountability and transparency in the use of funds is important for Member States, as is predictable and sufficient funding for PHC. Health insurance schemes and innovative public-private partnerships can also lead to improvements in health outcomes.
 - iii) *A well-qualified health workforce is needed for successful PHC implementation.* This has been a consistent theme throughout the review. An effective PHC system needs a skilled health workforce and interdisciplinary teams. Generating a health workforce that is adequate in terms of size and qualifications depends on the quality of health education and training, salary levels and regulatory frameworks. Equity of access and care depends on a sufficiently large health workforce that is sufficiently incentivized (financially or otherwise) to work in more remote or underserved populations.
 - iv) *Community participation and engaged users improve access and quality of care.* Inclusive participation is essential to ensure that health systems remain people-centred and health solutions are tailored to meet community needs. Engaging users of PHC services with local policy-makers is important for a successful PHC system. It is also important to ensure adequate regulatory frameworks and accountability mechanisms in health systems.
 - v) *Evidence-based actions require improvements in collection and use of data.* In the desk review, data- and evidence-driven approaches were noted as key to effective and efficient PHC implementation. For governments and other health sector staff to make well-informed decisions, the generation and use of data and evidence are crucial. However, government capacity to collect, analyse and use data is often subject to significant capacity constraints.

4. Conclusions and way forward

91. In the Alma-Ata Declaration of 1978, the signatory Member States “express(ed) the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world”.³⁸ Setting a goal of “the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”, Member States placed PHC at the centre of this goal and articulated the core elements of PHC described elsewhere in this report. Member States underlined the need “to exercise political will, to mobilize [their respective countries’] resources and to use available external resources rationally”, and for WHO, UNICEF and other international organizations to support them in their efforts.

92. On the occasion of the fortieth anniversary of the Alma-Ata Declaration, participants at the Global Conference on Primary Health Care held in Astana, Kazakhstan on 25 and 26 October 2018 issued the Astana Declaration “reaffirming the commitments expressed in the ambitious and visionary Declaration of Alma-Ata of 1978 and the 2030 Agenda for Sustainable Development, in pursuit of Health for All”.³⁹ In doing so, they committed to “make bold political choices for health across all sectors”, “build sustainable primary health care”, “empower individuals and communities” and “align stakeholder support to national policies, strategies and plans”, namely through knowledge and capacity-building, human resources for health, technology and financing.

93. Within this context, the present review, requested by the WHO Executive Board at its 142nd session in January 2018,⁴⁰ presented an early opportunity for Member States to take stock of 40 years of PHC implementation. The review sought to: document global progress towards PHC implementation, identifying achievements, success stories and best practices as well as challenges; identify intersectoral approaches which have been implemented for PHC; examine the extent to which PHC and related innovations helped to improve health outcomes, equity, intersectoral collaboration and efficiency; and identify the enabling factors and challenges in developing and implementing PHC approaches in countries over the past 40 years. Looking forward, the review aimed to identify lessons and innovations from different country and regional technical/development contexts that can be adapted and shared to promote and scale up future efforts in UHC as well as PHC, and to make recommendations on the way forward in order to accelerate national, regional and global health strategies and plans for UHC/PHC and the SDGs.

4.1. Global progress towards PHC implementation

94. As Member States noted in their positive overall self-assessment of their respective countries’ progress since the Alma-Ata Declaration, the past 40 years have witnessed a number of significant achievements in the implementation of PHC. Many health indicators have continued to improve in most countries and, on the whole, people are healthier and are living longer today than 40 years ago. Accordingly, numerous Member States focused on the end outcome of improvements in both the level and equity of health in their populations as one of the foremost achievements over the past four decades. As the review highlighted, various aspects of PHC implementation were considered to have been instrumental in achieving these outcomes, with particularly significant progress in coverage of basic health care, immunization coverage and the eradication and control of a number of infectious diseases. In many countries, these achievements have been realized not only in the overall population,

³⁸ Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 (https://www.who.int/publications/ Almaata_declaration_en.pdf, accessed 28 October 2019).

³⁹ Declaration of Astana. Geneva: World Health Organization and the United Nations Children’s Fund (UNICEF); 2018 (WHO/HIS/SDS/2018.61; <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>, accessed 28 October 2019).

⁴⁰ See document EB142/2018/REC/2, summary record of the eleventh meeting, section 2.

but rather also among subsegments of the population traditionally marginalized or particularly vulnerable for geographic and socio-economic reasons; in so doing, these countries have made substantial progress toward the equity aims of PHC.

95. Underpinning these accomplishments have been policy changes aimed to integrate the principles and goals of PHC within countries' health systems. In some countries, these policy changes have led to targeted and incremental refinements of specific aspects of their existing health systems. In other countries, these changes have resulted in more fundamental reform of countries' health systems to bring them into line with the principles and goals of PHC for equitable, effective, efficient and responsive health care. In numerous countries, these policy actions have translated into increased expenditure on health systems and specifically on PHC-centred health systems.

4.1.1. Intersectoral approaches which have been implemented for PHC

96. One of the main elements of these reforms has been the move towards greater intersectoral collaboration. Such intersectoral approaches have encompassed, first and foremost, collaboration between ministries of health and various other ministries whose work is mutually reinforcing with the goals of the health sector. Importantly, they have included other levels of collaboration as well, for example: strengthened collaboration among the various health professions and disciplines; collaboration across various sectors of society (including CSOs, NGOs and CBOs) and more generally between governments and NSAs; and collaboration between and among separate levels of government and public administration (such as health authorities at the national, regional and local levels). This whole-of-government, whole-of-society, Health in all Policies approach constitutes an achievement in its own right for many countries.

4.1.2. Innovations

97. This review emphasized that implementation of PHC has not been a formulaic undertaking, but rather has been accomplished through a wide range of innovations that constitute a subcategory of achievements themselves. The latter half of the post-Alma-Ata era has witnessed vast advances in information and communications technology that have revolutionized the delivery of PHC. Innovations have come in less technology-related ways as well. For example, some have focused on improving service provision or enhancing the management of PHC; others have comprised structural and administrative innovations to devolve decision-making to levels of government closer to the populations they serve; while others have focused on initiatives to empower communities and individuals themselves to take a more active role in their health. A range of other innovations have centred on strengthening the resourcing of health, in terms of both financial and human resources.

4.1.3. Extent to which PHC and related innovations helped to improve health outcomes, equity, intersectoral collaboration and efficiency

98. Although vast gains have been made in health outcomes over the past four decades, it is unclear to what extent these gains can be attributed directly to PHC implementation. This information gap is unsurprising, as discussions surrounding the 2030 Agenda for Sustainable Development and SDGs have highlighted the gap in results-level data globally. That said, many Member States nonetheless maintain that implementation of PHC has indeed contributed to overall improvement in health outcomes as well as equity.

4.1.4. Challenges

99. In spite of the significant gains achieved globally in the implementation of PHC, the review highlighted that such progress has been uneven both between and within countries, posing ongoing challenges to achieve equity. Beyond this overarching challenge, the review identified a wide range of areas that have frustrated efforts to achieve the goals of PHC. Although there have been many noteworthy gains in some countries, the area of human resources for health has been a longstanding issue and remains an outstanding challenge in most countries' PHC implementation efforts. Similarly, although most countries at all development stages have increased their funding to PHC, health

financing has remained inadequate, not least of all in light of increasing demand for health care, escalating health care costs and economic volatility. Despite vast advances in ICT, those advances have not always been effectively taken up and used at scale to positively impact health and well-being and, in many countries, data have been of poor quality, limited or non-existent, or available but underutilized.

100. Another broad category of challenges revolves around the many facets of quality of care. At the broadest level, numerous Member States maintained that low quality of services, long waiting times and difficulties obtaining medical appointments represented some of their key challenges. In those Member States where primary care practitioners were involved as gatekeepers in order to reduce inappropriate demands on costly secondary and institutional care, referral processes did not always function as intended, contributing to fragmented or misdirected care. Elsewhere, especially in countries affected by conflict, poor health infrastructure is a significant factor that negatively affects quality of care.

101. At the highest level, one critical challenge highlighted in the review centres on the very intent of the Alma-Ata and Astana Declarations: the political will of governments to implement PHC, including the related area of governance. Numerous Member States indicate that they still face challenges in generating and sustaining this political will. In other countries, political will might be present, but the policy context is inconducive to undertaking the ambitious changes necessary to implement PHC: policy agendas, policy design, policy coherence and governance have often been inadequate, as has the regulatory framework for PHC. In some countries, government engagement with NSAs has been weak. In others, political instability or conflict have significantly hampered PHC implementation efforts.

4.1.5. Enabling factors and challenges in developing and implementing PHC approaches

102. The review revealed a wide range of often interrelated factors that help to explain the range of achievements and challenges encountered over the past four decades. For example, political will is one of the key factors consistently cited as supporting PHC implementation while its absence is seen as constituting a key challenge for many Member States. Conversely, financial protection measures are reported as positively affecting PHC implementation as well as an achievement in many countries. Other key factors include: vibrant CSOs and the level of involvement of other NSAs in a given country; the availability and effective distribution of skilled human resources for health; the degree of donor-driven intersectoral coordination; and the extent to which data- and evidence-driven approaches are used to implement PHC.

103. However, the review revealed a much broader set of contextual factors that have affected PHC implementation globally. Rapid globalization of the world economy has significantly shaped PHC in a wide range of ways, some of these positive and others less positive. Broad demographic trends have resulted in older populations living longer lives, but not necessarily longer and healthier lives, and often without the population replacement by economically active younger cohorts to adequately support increased longevity. Globally, the increasing burden of NCDs, injuries and disabilities in relation to CDs represents another key shift in the global context affecting the implementation of PHC. Intra-state conflict, meanwhile, has placed a significant burden on those countries party to such conflicts – as well as those not party to the conflicts.

4.2. The way forward

104. The Astana Declaration takes a clear forward-looking view of PHC implementation, explicitly anchoring its vision for the future of such implementation in the 2030 Agenda for Sustainable Development and the SDGs. More recently, the linkage between PHC, UHC and the SDGs was reaffirmed by Member States at the high-level meeting of the United Nations General Assembly on universal health coverage on 23 September 2019.¹ In the political declaration ensuing from this

meeting, PHC was considered to be “the cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals”.⁴¹ The underlying lessons from this review could thus help inform the way forward.

4.2.1. Lessons

105. Despite the wide range of experiences globally over the past 40 years, many of the lessons emanating from these experiences can be consolidated into a much smaller subset of guideposts moving forward. Framed as lesson statements, these include the following:

- **The translation of political will into action is a prerequisite for achieving the principles and objectives of PHC.** In both in the Alma-Ata and Astana Declarations, the international community committed itself to action on PHC. As this review suggested, some countries have translated this commitment into a broad range of concrete policy actions, strategies and regulatory frameworks – as well as financial resources that are commensurate with their ambitious commitments. Other countries have seen less progress in translating their commitments into concrete action for various reasons. One lesson emerging from this review is that, in order for implementation to be effective in realizing the objectives and principles of PHC, commitments require political will to be translated into concrete and consistent policy action, and resources.
- **Successful PHC implementation calls for broad-based partnership.** The Astana Declaration in particular calls on governments, as well as the UN system (WHO, UNICEF and other international organizations) and NSAs (CSOs, CBOs, NGOs, and the private sector) to work in partnership towards the goals of PHC. The extent and strength of such partnerships have varied considerably from one country to the next, however.
- **Intersectoral collaboration, a core component of PHC implementation, requires concerted effort.** This review underlined that intersectoral collaboration is multifaceted, extending well beyond interministerial collaboration between the health sector and other sectors. Rather, intersectoral collaboration can be between and among health specializations, between various sectors of society (the broad-based partnerships described above) and between and among levels of government and public administration. This review suggested that promoting these various forms of collaboration has been challenging and requires commitment translated into action as described above.
- **Equity remains an ongoing challenge.** Overcoming inequities both within and between countries is a stated commitment in the Alma-Ata and Astana Declarations, and yet it remains a persistent challenge. Many countries have made great strides in their efforts to translate the commitment to health as a human right into concrete actions to ensure equity within their borders. Many others have made less progress. Inequities persist between countries as well, with some lacking the resources or capacity and others struggling to generate the domestic political will to achieve equity.
- **A sufficiently large, and sufficiently qualified, health workforce is necessary to attain the goals of PHC.** Human resources for health – and specifically attracting, managing and retaining a suitably sizeable and suitably qualified health workforce – emerges as a consistent theme in the present review. Importantly, as the experience of numerous countries underlines, in order for the goals of PHC to be realized, it is vital that the health workforce be trained not merely in the technical aspects of their respective professions, but rather also in the principles and objectives of PHC.

⁴¹ Political Declaration of the High-level Meeting on Universal Health Coverage: “Universal health coverage: moving together to build a healthier world” (<http://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>, accessed 28 October 2019).

- **Various aspects of PHC implementation can be incentivized.** As numerous examples in this review indicated, the goals of PHC need not always be dictated but can rather be prompted through various incentive modalities. A few such examples include the use of salary incentives to attract and retain the health workforce, financial incentives to reward achievement of desired outcomes in medical practices, incentives to foster intersectoral collaboration and incentives to foster innovation.
- **To develop and sustain PHC systems in the future, continued innovation will be crucial.** Although it was not assumed in the review that innovation is inherently positive or always has exclusively positive outcomes, the review showcased numerous innovations that have helped countries to seize on opportunities and tackle challenges in PHC implementation. These innovations are not limited to technology, but also entail creative solutions to help refine processes, reconfigure health finance approaches, restructure public administration and reform entire health systems to make them more people-centred, cost-efficient and equitable. In light of the continued challenges to PHC implementation, coupled with the significant trends in the global context highlighted in this review (such as ongoing globalization, ageing populations, the shift of burden on health systems to NCDs, and conflict in some countries), the need for innovative problem-solving will likely continue to grow.
- **Evidence-based approaches can help maximize success in PHC implementation.** As the review revealed, some countries have actively sought to bring relevant evidence to bear on their PHC-related decision-making processes, while others have taken a less systematic approach. By learning from existing sources of knowledge, information, data and experience, countries can develop well-informed policies, programmes, strategies, regulatory frameworks, incentive structures and innovations based on what has worked (and what has not) rather than pursuing less evidence-based (and potentially less certain) options. The rapid development of ICT in countries at all levels of development has served to facilitate the generation and sharing of knowledge, which can be key to accessing and using evidence.

4.2.2. Further considerations for the way forward

106. With this broad overview of the achievements, challenges, enabling factors and lessons in hand, a number of areas for future action in the implementation of PHC can be identified. Emanating from responses in the Member State survey, these recommendations can be categorized as follows.

Actions for governments

1. Strengthen, or continue to strengthen, the commitment to primary health care by translating this commitment into concrete actions (such as policies, strategies, regulatory frameworks, strengthened governance and broader reforms) through evidence-based approaches wherever possible.
2. Match this political will with financial commitment – in terms of both overall funding of primary health care-based approaches and specific measures – to improve financial protection of the population.
3. Undertake measures to ensure that human resources for health are adequate both in quantity and in quality – “quality” being grounded in primary health care principles and objectives as well as in technical expertise.
4. Enhance efficiency, seeking to achieve better value for money from existing health spending by streamlining service delivery, reducing waste and discouraging services without proven benefit.

5. Strengthen intersectoral collaboration within government by embedding whole-of-government, Health in All Policies approaches into policies, strategies, governance, and incentive mechanisms.
6. Strengthen whole-of-society approaches through better engagement with nongovernmental actors such as communities, the private sector and other non-State actors.
7. Strengthen primary care services through further development and uptake of digital technologies, incentives for providers, establishment of organizations and relationships to foster more integrated service delivery and multiprofessional teamwork, more effective management of the interface between primary and secondary care (through gatekeeping and enhanced referral mechanisms through primary care) and an adequately trained health workforce
8. Foster and support primary health care innovation as well as evidence-based approaches.

Actions for WHO and other actors⁴²

107. Respondents proposed the following actions for WHO to be implemented in collaboration with relevant United Nations agencies, non-State actors and other partners:

1. WHO should continue to harness its convening role to foster intersectoral collaboration in the various forms described in the review, both at the global policy level and in individual countries in its support to governments.
2. In its normative role, WHO should continue to lead in the development of standards and policy and operational guidelines for the further implementation of primary health care pursuant to the commitments outlined in the Astana Declaration and, by extension, the 2030 Agenda for Sustainable Development and Sustainable Development Goals.
3. In its technical cooperation role, WHO should tailor its capacity-building efforts to the specific primary health care-related areas requiring further support identified in specific countries, for example, strategy development and implementation, health systems strengthening, Health in All Policies, health legislation, health financing, health technology assessment and management, human resources for health, community health approaches, research to improve service delivery, and monitoring and evaluation of primary health care implementation through support to voluntary national reviews or other means.
4. In its advocacy role, WHO should identify and target the specific primary health care-related issues requiring such advocacy in individual countries, for example by advocating for increased health expenditure, identifying specific policy gaps requiring action and emphasizing the need for greater intersectoral collaboration and greater equity.
5. In fulfilling all of these roles, WHO should enhance its support to evidence-based policy action, for instance by supporting systematic research and evidence generation to support policy-making in health, and documenting and disseminating lessons and best practices.

⁴² In the Member State survey, respondents were asked to identify potential areas of action for WHO and other actors. However, the vast majority of responses revolved around the potential role of WHO moving forward.

Annex 1: Terms of reference⁴³

PROPOSAL FOR REVIEW OF 40 YEARS OF PRIMARY HEALTH CARE IMPLEMENTATION AT COUNTRY LEVEL

Background

In January 2018, the 142nd session of the Executive Board requested the Evaluation Office to conduct a review of 40 years of primary health care implementation at country level. Furthermore, the Board requested the Secretariat to present to the 144th session of the Board an outline of the scope and framework for such a review.

Purpose

The overall purpose of the review is to: (a) document global progress towards primary health care implementation, identifying achievements and success stories, best practices and key challenges encountered; and (b) make recommendations on the way forward in order to accelerate national, regional and global health strategies and plans for universal health care/primary health care and the Sustainable Development Goals.

Scope and approach

The scope of the review will be informed by the Global Conference on Primary Health Care (Astana, Kazakhstan, 25 and 26 October 2018), the forthcoming report of the Regional Office for the Americas/PAHO High-level Commission on Universal Health in the 21st Century: 40 years of Alma-Ata, and other reviews of primary health care implementation. Covering the 40-year period from the 1978 Alma Ata Declaration on primary health care to 2018, the review will assess global progress towards primary health care implementation through two complementary information sources: (a) a systematic review of existing published data sources; and (b) an assessment of country-level implementation through Member State engagement and inputs obtained by means of an online questionnaire for all Member States.

The overall process and methodological approach will follow the principles set forth in the WHO Evaluation Practice Handbook and the United Nations Evaluation Group Norms and Standards for Evaluation and Ethical Guidelines for Evaluation. The review will also adhere to WHO cross-cutting evaluation strategies on gender, equity, vulnerable populations and human rights, and include, to the extent possible, disaggregated data and analysis.

The review will aim to address the following key questions:

- (a) What have been the enabling factors and challenges in developing and implementing primary health care approaches in countries over the past 40 years?
- (b) How have primary health care and related innovations helped to improve health outcomes, equity, intersectoral collaboration and efficiency?
- (c) What intersectoral approaches have been implemented for primary health care?

⁴³ See document EB144/51, paragraphs 15 to 20.

- (d) What lessons and innovations from different country and regional technical/development contexts can be adapted and shared to promote and scale up future efforts in universal health care/primary health care?

The review will be conducted by the Evaluation Office. The review process will be initiated during the first quarter of 2019. The final report will be issued during the last quarter of 2019 with key findings presented to the Executive Board at its 146th session in January 2020.

Annex 2: Online survey for Member States



World Health
Organization

Review of 40 years of primary health care implementation at country level Member State questionnaire

Dear National Focal Point,

Thank you very much for serving as the national focal point for this *Review of 40 years of primary health care implementation at country level*, which was requested by the WHO Executive Board at its 142nd session in January 2018.

As described in the terms of reference for this review, which were noted by the Executive Board at its 144th session in January 2019 ([EB144/S1](#), paragraphs 15-20), the purpose of this review is to: (a) document global progress towards primary health care implementation, identifying achievements and success stories, best practices and key challenges encountered; and (b) make recommendations on the way forward in order to accelerate national, regional and global health strategies and plans for universal health coverage/primary health care and the Sustainable Development Goals.

The review covers the 40-year period from the Alma Ata Declaration on primary health care to the present (1978-2018). It aims to assess global progress towards primary health care implementation through two complementary information sources, namely:

1. a systematic review of existing published data sources; and
2. an assessment of country-level implementation through Member State engagement and inputs obtained by means of an online questionnaire for all Member States.

This questionnaire is therefore an important component of the review.

The following points might be helpful during your completion of the questionnaire:

- **Period reviewed.** This review aims to fully cover the period since the Alma Ata Declaration. We would therefore ask that you kindly answer the questions to the best of your knowledge for this period.
- **Single, consolidated response.** Completion of the questionnaire may require wider consultation. However, please note that only one consolidated questionnaire can be accepted per country. *We would be happy to send you a word or PDF version of the document should this be necessary for consultation purposes.*
- **Supporting documents.** In case you or others would like to share key documents that might help the review team understand one or more of your responses, an opportunity is provided at the end of the questionnaire for you to upload these.
- **Confidentiality.** Your answers will be completely anonymous and strictly confidential as the responses given will only be reported at an aggregate level.
- **Submission deadline.** So that your inputs can be included in the analysis, **we kindly ask that you submit the completed consolidated questionnaire by Friday, 5 July 2019.**

Should you have any questions about the review or this questionnaire, please contact evaluation@who.int.

Thank you very much for completing this questionnaire – and for your contribution to this review.

PART A: Background information

Q1. On behalf of which Member State is this questionnaire being submitted?

As noted above, your responses in this questionnaire will be held in strict confidence, and the review report will not mention any specific country by name. The reasons for collecting this information are to:

- (a) enable the review team to understand the specific achievements, challenges, best practices and lessons in each country within its specific context;
- (b) uncover any patterns among and across countries; and
- (c) enable cross-referencing of information uncovered in the desk review component of the review.

PART B.1: Progress and challenges in primary health care in your country, 1978-2018

Box 1: The Term “Primary Health Care” (PHC) in This Review

Although the concept of primary health care (PHC) has been used in various ways over time, PHC as described in the [Alma Ata Declaration](#) itself serves as the foundation for the understanding of PHC in this questionnaire. All questions referring to PHC are based on the various aspects of PHC stated in the Declaration.

Q2. Based on the various aspects of PHC as described in the Alma Ata Declaration, what have been the key elements of PHC in your country over the past 40 years?

Examples might include: any key aspects of PHC given particularly high priority in your country; ways in which your country has interpreted and applied the various aspects of PHC within your country context; aspects of PHC not captured in the Declaration that your country has pursued; or anything else you would like to highlight.

Q3. How successful has the implementation of PHC been in your country overall?

This review aims to fully cover the period since the Alma Ata Declaration. We would therefore ask that you kindly answer this question to the best of your knowledge for this period.

Very Successful <input type="radio"/>	Somewhat Successful <input type="radio"/>	Somewhat Unsuccessful <input type="radio"/>	Very Unsuccessful <input type="radio"/>
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PART B.2: Progress and challenges in primary health care in your country, 1978-2018

For each of the following questions, please feel free to highlight the most relevant and significant examples from your country's experience. We would kindly ask that these responses be as specific as possible, conveying the key details of the achievement at hand, but also as concise as possible to allow the large volume of information provided by many countries to be meaningfully analysed within the time frame allocated for the review.

Q4. What would you consider to be the key achievements in the implementation of PHC in your country?

Q5. What have been the enabling factors in developing and implementing primary health care approaches in your country?

"Enabling factors" are those key factors that helped facilitate your country's progress in developing and implementing PHC to date.

Q6. What have been the greatest challenges in developing and implementing primary health care approaches in your country?

"Challenges" are those key factors that contributed to any lack of progress in developing and implementing PHC in your country to date.

Q7. What intersectoral approaches have been implemented for PHC in your country?

Q8. What important innovations have been introduced in the implementation of PHC in your country?

Q9. What if any effects has your country’s implementation of PHC (including related innovations) had in your country more widely?

Such wider effects might include, for example, effects on health outcomes, equity, intersectoral collaboration, or efficiency.

PART C: Looking ahead

These last few questions ask you to consider the future direction of PHC, particularly in relation to the 2030 Agenda and the Sustainable Development Goals (SDGs) – specifically SDG Target 3.8 (“Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”).

Q10. What lessons, best practices, and innovations from your country’s experience can be adapted and shared to promote and scale up future efforts elsewhere in the implementation of PHC – and the achievement of Universal Health Coverage (UHC), in line with SDG 3.8?

Q11. What key challenges do you see your country facing in its own efforts to fully implement PHC and achieve SDG 3.8 by 2030?

Q12. What efforts need to be undertaken in the future by governmental actors at the national and subnational level in your country so that PHC can be fully implemented and SDG 3.8 achieved by 2030?

Q13. What specific role do you see WHO and other partners (e.g., nongovernmental organizations, community-based organisations, civil society, the private and philanthropic sectors, other UN entities) playing in the future to support PHC implementation in your country?

Q14. Do you have any other comments you wish to provide in relation to PHC implementation in your country?

THANK YOU ONCE AGAIN FOR YOUR PARTICIPATION IN THIS QUESTIONNAIRE.

PLEASE FEEL FREE TO UPLOAD ANY DOCUMENTS YOU WOULD LIKE TO SHARE HERE:

Annex 3: List of documents reviewed

High-level desk review

From Alma-Ata to Astana: primary health care – reflecting on the past, transforming for the future. Interim report from the World Health Organization European Region. World Health Organization Regional Office for Europe; 2018.

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Egypt: Country Case Studies on Primary Health Care: Egypt: Health Sector Reform. World Health Organization; 2018.

El Salvador: Country case studies on primary health care: El Salvador: Territorial Community Teams. World Health Organization; 2018.

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Estonia: Country case studies on primary health care: the development of family practice to support universal health coverage. World Health Organization; 2018.

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