

Evaluation: update and proposed workplan for 2020–2021

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

Executive summary

Report by the Secretariat

1. The Executive Board, at its 142nd session (2018), requested the Evaluation Office to conduct a review of 40 years of primary health care implementation at country level.¹ An outline of the scope and framework for this review was presented to the 144th session of the Board (2019) for its consideration.²
2. In accordance with the modalities of this review, the Evaluation Office is submitting the executive summary of the review to the 146th session of the Executive Board (see Annex).³

ACTION BY THE EXECUTIVE BOARD

3. The Board is invited to note the report.

¹ See document EB142/2018/REC/2, summary records of the eleventh meeting, section 2.

² See document EB144/51, paragraphs 15 to 20.

³ The full report of the review of 40 years of primary health care implementation at country level is available on the website of the Evaluation Office: see www.who.int/evaluation, accessed 1 November 2019.

ANNEX

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

EXECUTIVE SUMMARY

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”.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.

2. 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

3. 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.

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).

4. On the occasion of the 40th 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”.¹ 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.

5. 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 2018.² 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.³

6. 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 “programmatic engine for [universal health coverage] in most contexts”⁴ 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

¹ 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).

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

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

⁴ 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).

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”.¹

- **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 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.

7. 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.²

8. The overall process and methodological approach followed the principles set forth in the *WHO evaluation practice handbook*³ and the United Nations Evaluation Group *Norms and Standards for Evaluation and Ethical Guidelines for Evaluation*.⁴ 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.

¹ 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).

² Responses were received from 49 Member States and one territory.

³ 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).

⁴ 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).

Key findings

9. 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.
- (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 Millenium 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 primary health care implementation

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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, particularly 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.

16. 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.

17. 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.

18. 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.

19. 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

20. 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”.¹ The underlying lessons from this review could thus help inform the way forward.

21. 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

¹ 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).

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 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.

22. 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 actors¹

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.

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¹ 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.