PROGRESSING PRIMARY HEALTH CARE:
A SERIES OF COUNTRY CASE STUDIES
Acknowledgements

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In addition, the series includes five cases that are extracted from the publication “Progressing the Sustainable Development Goals through Health in All Policies: case studies from around the world” (http://www.who.int/social_determinants/publications/progressing-sdg-case-studies-2017.pdf?ua=1) published by the Government of South Australia and WHO. Licensed under CC BY NC-ND 2.5 AU https://creativecommons.org/licenses/by-nc-nd/2.5/au/.

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The 1978 Declaration of Alma-Ata (1) was revolutionary. Many countries, the World Health Organization (WHO), the United Nations Children’s Fund (UNICEF) and other organizations had been pursuing strategies to provide primary health care (PHC) for years (2). However, Alma-Ata made PHC central to health care policy and practice. In a world in which resources had long been focused on “vertical” health programmes, expanding the focus of health care was a novel approach for the global health community. Since this declaration, efforts to improve health have increasingly been framed in terms of building, strengthening or realigning the systems that contribute to a more expansive notion of health for the entire population.

In 2018, in support of the Global Conference on Primary Health Care and the Declaration of Astana, WHO commissioned a series of case studies on various countries that have delivered PHC reforms over the past four decades. These case studies illustrate different aspects of PHC reform, focusing on successful interventions but also highlighting ongoing challenges. They were chosen to represent the experience of a diverse range of countries, each with different population health needs, health system development, and levels of resources.
The aim of the series is to demonstrate how commitment to PHC can be translated into action, highlight common challenges, showcase what has worked well, and provide examples for policymakers and other stakeholders who are committed to transformation in support of PHC. The cases include those that focus on health sector reform, and those using the “health in all policies” (HiAP) approach. The cases can be summarized as follows:

- Australia – Lessons from 10 years of HiAP in South Australia;
- Brazil – the Mais Medicos Programme;
- Canada – Quebec’s policy of prevention in health, a HiAP approach;
- China – Multidisciplinary teams and integrated service delivery across levels of care;
- Egypt – Health sector reform;
- El Salvador – Territorial community teams;
- Estonia – The development of family practice to support universal health coverage;
- Finland – How to take into account health, well-being and equity in all sectors;
- Ghana – Community engagement, financial protection and expanding rural access;
- Jamaica – Development of workforce for first level of care;
- Kazakhstan – Technology to support disease management in primary care;
- Samoa – Engaging people for health promotion;
- Sri Lanka – Community-based workforce development for maternal and child health;
- Sudan – HiAP experience;
- Suriname – Reducing the burden of disease and health inequity through HiAP;
- Thailand – Development of primary care;
- Turkey – Family practice for quality in universal health coverage; and
- Viet Nam – Improving equity in access to primary care.
Context

The world is facing profound social, ecological, political, epidemiological and demographic transitions. PHC provides a society-wide approach to respond to these challenges; hence, world leaders are coming together to renew their commitment to PHC. As the cases highlighted here demonstrate, PHC advances UHC, and contributes to the attainment of health-related targets of the Sustainable Development Goals (SDGs), including those on poverty, hunger, education, gender equality, clean water and sanitation, work and economic growth, reducing inequality, health and climate action.
Methods for the development of case studies

The cases focus on countries that have committed leadership and resources to strengthening PHC. Although several of these countries initiated their programmes in response to the Declaration of Alma-Ata, others had started their work well before 1978. Existing case studies (See References 3–5 and the HiAP cases) were used for the studies, supplemented by targeted review of key global reports, peer-reviewed literature, and focused searches of governmental and civil society websites to develop the cases focused on individual reforms. The aim was to understand the key problem addressed, models implemented, paths taken towards PHC, and the major challenges.

Previously published WHO cases on health in all policies were collated and republished for the conference (6). In addition, a new series of case studies was written to provide specific examples of pathways to improving PHC. For these cases key informants were interviewed – generally experts from the country’s ministry of health (MoH) or academic institutions – to provide further insights into how and why strategies were chosen, adapted and implemented, and where additional work is needed. The evidence was synthesized for each country and revised following review by country informants and WHO. The case studies were also peer-reviewed by international PHC experts. This overview (‘chapeau’) document uses thematic grouping to identify common lessons across the new country case studies.
Findings

Three main themes emerge from the case studies: local adaptation and community engagement, iterative rollout, and sustained political commitment to equity. These themes are discussed below.

PHC is local

The PHC reforms covered well-trodden ground: improving access to well-trained local health teams; broadening the comprehensive scope of services offered; coordinating across levels of service and integrating non-health sectors; and providing higher quality, person-focused care. Although the interventions were generally similar in form, implementation required local adaptation, community engagement and long-term partnerships.

A core principle of the Declaration of Alma-Ata is local adaptation and community ownership. The cases show that PHC has flourished when implemented with meaningful community engagement. The factors that make community engagement “meaningful” are just as locally determined as any other aspect of PHC. In Samoa, for example, a combination of broad and deep engagement has been found to be effective. Those implementing PHC in Samoa take advantage of community meeting spaces and times to share information broadly with the members of the community, but they supplement this approach by engaging specific members of the community in functionally significant ways. Samoa has adapted WHO’s Package of Essential Noncommunicable Disease Interventions (PEN). During screening for noncommunicable diseases (NCDs), the PEN Fa’a Samoa programme tasks local volunteer facilitators with collecting demographic and basic health data (e.g. height, weight and symptoms) in partnership with a provider who collects clinical data (e.g. blood pressure and cholesterol measurement). The local facilitators also follow up individually with patients who require referral for NCD care or an individual management plan. Similarly, the Islamic Republic of Iran relies on community practitioners (Behvarzes) who originate from the community in question. The country has assigned these providers significant responsibilities, such as provision of health education, maternal and child health services, health services for the elderly and occupational health services.
In other countries, successful community engagement relies on factors other than local village staffing. Ghana’s Community-Based Health Planning and Services (CHPS) programme places community nurses within their home regions, but not necessarily directly in their home communities. Thus, the nurses speak the local language, but maintain sufficient social distance to be effective providers. Ghana has found that it can increase programme adoption by encouraging local communities that have successfully implemented CHPS to mentor those who have not yet implemented CHPS, through an exchange programme. Thus, community members become integral participants, embedding the programme in the community and embedding local knowledge in the programme. Similarly, Thailand relies on mandatory rural service, financial incentives, social recognition and well-equipped workplaces to draw non-local providers to rural areas and to encourage them to stay in those areas. Successful integration into the community has greatly depended on local availability of services and financial access to care. In El Salvador, family health teams use data from their mobile ehealth records to identify and address local causes of disease. This allows interventions to be tailored to the real-time needs of the community, and thus to make efficient use of resources.

The cases make it clear that the communities are involved “from the ground up” – literally, in the case of Ghana, where the communities are responsible for building the CHPS compounds. In the Islamic Republic of Iran, the training of the Behvarzes is locally managed; therefore, communities can, and do, tailor practitioners’ training to their local issues and resources. Similarly, in Sri Lanka, the cadres of public health nursing sisters and midwives are deeply integrated into the local communities, which has led to relationships that build stronger trust between them and the communities they serve. Integrating community viewpoints and support at all fundamental levels helps to ensure that a programme will be successfully adapted and implemented within that locale.
Reform is iterative

Successful implementation takes time and repeated iteration, based on performance data and stakeholder feedback. Reforms cannot focus solely on expansion of clinical services. Most successful reforms were efforts that had continued over several decades, combined with health financing reforms that enabled broader population coverage of higher quality services and more sustainable payments to PHC providers.

Successful PHC at scale takes significant time and persistent effort; implementation efforts are measured in years or even decades, and thus require proper adjustment of timescales. Egypt and Ghana have both been implementing their PHC interventions for 14 years, and have seen significant improvement in health outcomes despite significant sociopolitical challenges. The Islamic Republic of Iran and Viet Nam have each taken nearly a quarter-century to do roll out PHC reform. Successful implementation over nearly 25 years requires not only charismatic individuals and immediate funding, but also institutional persistence and political will, both of which must be dedicated to making PHC successful in every community across the country. Such persistence and will is best sustained, the case studies suggest, by continuous improvement that is iterative and data driven.

All the countries represented here sought to “start small” with pilot programmes or otherwise limited implementation before rolling out their programmes to the entire country. They also started by addressing challenges and barriers sequentially or in manageable stages. For example, when Estonia regained its independence in 1991, the country was awash with support for social, economic, political and health care reforms. Taking advantage of that energy, Estonia first passed health insurance reform, then made family medicine a specialty and began retraining other specialists in family medicine. As the initial rush of reforms began to fade, Estonian leaders persisted in passing further iterative health care reforms, including empanelment and performance-based payment. Today, decades later, they continue to face the next series of challenges, including strengthening the health workforce, resolving long wait times and closing gaps in care coordination. By approaching their system problem by problem, the Estonians have been able to implement 27 years of health care reforms centred on PHC.

Viet Nam, by contrast, addressed financing, health insurance and infrastructure roughly in parallel, but approached each challenge in stages. Thus, infrastructure upgrades began in 1996 with community health centres in the poorest provinces and, by 2011, the MoH had benchmarked 90 indicators covering areas such as facility criteria, equipment availability and staffing. Three years later, the MoH issued a list of essential medications and, in 2017, described the basic package of services that community health centres must provide. Thailand undertook similar parallel financing and service delivery reforms to mutually reinforce each other as the country moved towards a common UHC goal. As in Estonia, steady, sequential work in Thailand has yielded high dividends in both implementation success and health outcomes. In China, reforms in Anhui province merged expansion of financial coverage with health service reform and embedded PHC improvement within regional networks that hold accountability for the health of a defined population.
The need to build a long-term sequence for equitable success

PHC is expressly designed to improve outcomes while reducing inequality; social justice is not a mere byproduct of improving the health care system, it is often a parallel goal. In these case studies, we see an equity focus in both the goals and effects of initiatives: in Ghana, the National Health Insurance Scheme (NHIS) now provides a basic health insurance package that nearly every Ghanaian can register for (one of the first of its kind in sub-Saharan Africa), and that is intended to improve health care access for the very poor. As a result, new service providers have begun to be drawn to impoverished, rural areas because they now know they will be reimbursed for their PHC services by the NHIS. In Viet Nam, the National Health Support Project upgraded the infrastructure and equipment of community health centres in the poorest provinces first, and the country has continued to improve supplies, equipment and infrastructure in the ensuing 15 years. The result has been dramatic improvements in access, acceptability and affordability of care for everyone in Viet Nam, especially the poorest populations. Through its PHC reforms, the Islamic Republic of Iran aimed to reduce the drastic inequality between urban and rural health care service availability and quality that was found in the 1980s. Today, not only has rural health care reached parity with urban health care, but the country is seeking to model an urban PHC system on its much more successful rural programmes.

Just as PHC must be implemented community by community in a manner that enhances equity, it must also be implemented iteratively without falling into the trap of roll-outs that are inequitable or are siloed from other initiatives. Efforts to build, realign or strengthen health care systems are not quick (or easy or cheap), but must be sustained across time, different political climates and administrations, and various economic circumstances, societal sectors and social changes. Formulating national policies, strategies and plans of action, and exercising political will and mobilizing resources cannot be a one-time event, or even a 10-time event. In Thailand alone, PHC survived eight rival governments, six elections, two coup d’états and 13 health ministers, all in a period of only 15 years. National level work is just as continuous as community-by-community implementation, and it is time to start adopting the lessons from these and other case studies, to turn our policies, strategies and plans into the years and decades of action we need.
Conclusion

Although implementation of PHC will always be community specific, the objectives remain universal. There is no cut-and-paste reform; however, we see in these case studies the possibility for effective and sustained change with three core features. First, there needs to be the political will to implement PHC, and the implementation of PHC needs to account for local context. Second, PHC improvement is iterative; it requires integration with other sectors, and often concomitant financial and political reforms. Third, change requires long-term investment with a focus on helping the poorest and most marginalized in society. These case studies demonstrate a need for focused, iterative, community-based action on the part of every level of the health care system and society – from national leaders to local providers to the communities they serve – and a need for dedicated political will to innovate through, work around, move past, or just simply outlast the numerous, but not insurmountable, barriers for everyone, everywhere to live a healthy life.
References


COUNTRY CASE STUDIES ON PRIMARY HEALTH CARE