Realizing the potential of primary health care: lessons learned from the COVID-19 pandemic and implications for future directions in the WHO European Region

The role of primary health care (PHC) has been fundamental in the response to the current COVID-19 pandemic, and the pandemic has in turn underscored the importance of strong PHC. The pandemic has also underlined the importance of long-standing efforts to strengthen PHC and essential public health functions at the core of integrated health services, as endorsed in the Astana Declaration on Primary Health Care in 2018, affirmed by resolutions WHA72.2 and EUR/RC69/R8 in 2019, and as reaffirmed in the Operational Framework for Primary Health Care approved in 2020.

This working document sets out a proposed way forward to realize the potential of PHC and implement the commitments made in the European Programme of Work, 2020–2025 – “United Action for Better Health in Europe” (EPW), drawing on the lessons learned from the pandemic. The document situates PHC at the nexus of the three core priorities and four flagship initiatives of the EPW, emphasizing how PHC is a key area for investment if progress is to be made on the health-related Sustainable Development Goals. It aims to provide the rationale for strengthening PHC during the post-pandemic recovery and to discuss the policy and programmatic considerations that should be taken into account. In that respect, it is intended to provide supporting information to the related draft resolution that is submitted for adoption by the WHO Regional Committee for Europe.

This document is presented for consideration to the Regional Committee at its 71st session. The document reflects comments from two rounds of review by the Standing Committee of the Regional Committee for Europe (SCRC) and from virtual country consultations that took place between 24 March and 13 April with the participation of 35 Member States.
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Introduction

1. The COVID-19 pandemic has resulted in a dramatic loss of life, health and well-being in the WHO European Region. It has brought suffering to all and has adversely impacted the physical and mental health and the social and economic conditions of the people of Europe. The role of primary health care (PHC) has been and will remain fundamental in the response to the current pandemic to mitigate this adverse impact on health and well-being and alleviate human suffering.

2. PHC has played a dual role during the pandemic, where significantly increased responsibilities and demands have called for rapid adaptation and transformation. First, PHC has continued to deliver essential health services with renewed efforts to reach those in need. Secondly, in many countries, PHC has also supported the pandemic response through community surveillance, testing and contact-tracing efforts, the management of asymptomatic and mild COVID-19 cases, and the management and rehabilitation of post-COVID conditions. These tasks have translated into a dual reality for health care providers on the ground that entails balancing the continued provision of essential health services with the pandemic response. Overall, this has led to a dramatic increase in responsibilities and workload at the PHC level and has prompted rapid adaptation and transformation (for example, rapid uptake of remote consultation platforms and an unprecedented increase in mental health-related consultations), often accelerating planned and already initiated policies.

3. The pandemic has challenged the pursuit of solidarity, which is at the heart of the European Programme of Work, 2020–2025 – “United Action for Better Health in Europe” (EPW). On the one hand, a wide range of creative approaches to achieving solidarity have been documented at the community, regional and national levels; many of these go beyond state-led approaches by harnessing community spirit and volunteerism. On the other hand, practical barriers to a more effective delivery of services for the vulnerable have been identified. The pandemic thus provides an opportunity for learning and for translating these lessons into actions for stronger PHC services that truly leave no one behind.

4. The pandemic has provided new impetus to long-standing reforms and policies to strengthen PHC, as endorsed in the Astana Declaration on Primary Health Care in 2018, affirmed by resolutions WHA72.2 and EUR/RC69/R8 in 2019, and reaffirmed in the Operational Framework for Primary Health Care approved in 2020. The pandemic has magnified the importance of these commitments. Country experiences reveal the potential of proactive, people-centred PHC services to address a wide range of health and social conditions; they have also demonstrated the ability of providers, people and systems to adapt to new approaches and ways of delivering and receiving PHC services. While recognizing the challenges that many countries continue to face after decades of underinvestment in public health capacity and PHC, emerging experiences give grounds for optimism that change is possible to close the implementation gap between ambitions and commitments on the one hand, and actual progress on the ground on the other. In addition to harnessing these lessons, it is important to leverage innovations in order to realize the untapped potential of PHC-led health systems.

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Realizing the potential of PHC: policy considerations

5. PHC is at the nexus of the three EPW core priorities and constitutes a key area of investment if progress is to be made on the health-related Sustainable Development Goals (Table 1). An important lesson learned from the pandemic is the essential role of PHC as a provider of a wide range of services that matter to people and are accessible. Accordingly, PHC has been recognized as central to such major social goals as moving towards universal health coverage (UHC), protecting against emergencies, and promoting health and well-being. There is an opportunity to strengthen PHC in the post-pandemic period so that this potential is fully harnessed. To that end, PHC must be addressed as part of a comprehensive approach to the strengthening of health systems under an equitable social and economic development agenda that prioritizes holistic investment in people and in human capital. The lessons learned from the pandemic provide an opportunity to reaffirm political commitments to strengthening PHC and essential public health functions at the core of integrated health services and revisiting strategic directions and policy frameworks.

6. People- and community-centred PHC contributes to solidarity and fosters social cohesion. For PHC to be truly people-centred requires a commitment to rethinking service design and delivery in a way that takes people’s needs into account and ensures that they are fully involved. This requires connecting voices of people with that of professionals and community leaders through analysis of shared challenges, joint learning of lessons, and participatory priority-setting processes for a co-owned vision for the future transformation of PHC with integration of public health and social services. Such participatory approaches foster shared values and communication, thereby increasing mutual trust and generating the goodwill required to overcome implementation challenges and mobilize untapped resources.

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Table 1. PHC at the nexus of the three core priorities of the EPW

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What?
Core strategic directions for redesigning the service delivery model

- Tailor the model to reflect the burden of disease and socioeconomic risks in the population served
- Strengthen the foundations by providing more comprehensive services in general practice and family medicine
- Implement multi-profile, integrated, networked and team-based PHC organization
- Integrate selected specialist support into front-line services
- Implement multilevel quality improvement systems
- Leverage multimodal delivery to make services more accessible for people: face-to-face, mobile and digital
- Strengthen capacity for emergency responses, including such areas as surveillance, contact tracing, first response, case management, rehabilitation and follow-up
- Prioritize, adequately fund and monitor essential health services during emergencies
- Ensure accountability for population health and its determinants by building bridges between PHC and public health and social services
- Strengthen capabilities and systems to identify and contact people with health and social vulnerabilities in real time through PHC
- Engage civil society in united action with a view to promoting solidarity

How?
Enhanced health workforce composition, competencies and skills
Renewal of physical and digital infrastructure
Leveraging of organizational innovation and health management
Good governance, full coverage, greater funding and aligned incentives

Moving towards UHC

Getting the PHC model right through an approach tailored to national and local contexts

7. Recognize that one size does not fit all. Moving towards UHC requires closing gaps in unmet needs for essential health services, with a focus on those services that have a big impact in terms of reducing the burden of disease and mitigating socioeconomic risks. This in turn calls for the PHC models in individual countries to be strengthened, bearing in mind that the organization of PHC is unique in each country and a one-size-fits-all approach does not produce results. The art of closing the implementation gap between ambitions and results on
the ground lies in tailoring and contextualizing international good practices to national and local contexts. Given the rich variety of such contexts, the starting point for achieving a fit-for-purpose PHC model is to ensure that it reflects both population health needs (through the anticipatory design of health services) and individual health needs (by providing goal-oriented care tailored to individuals).

8. Invest in enhancing the quality of services, which translates into higher prestige for PHC workers and greater trust in the PHC system. The trust that a PHC system inspires and the prestige enjoyed by its health workers are critically important in terms of encouraging people to seek services at the right time and in the right place. Among other things, this requires the strengthening of multilevel quality improvement mechanisms so that PHC systems are able to offer multidisciplinary and holistic rather than fragmented disease-oriented approaches to care delivery. To make this happen, public health and medical education programmes need to be aligned with these principles. Additionally, clinical decision-making can be strengthened by generating and regularly updating evidence, by taking into account both clinical and non-clinical aspects of diagnosis, treatment and referral, and by translating these aspects into clinical protocols and guidelines and decision aids. Performance monitoring, benchmarking and feedback loops at the provider, community, regional and national levels are all practical ways of making continuous improvements and adjustments. Improved high quality services in PHC are better able to address the root causes of illness, can help to reduce overutilization of specialist and high-tech services, and can contribute to appropriate clinical pathways with timely referrals.

9. Establish multidisciplinary PHC teams. Multidisciplinary PHC teams addressing a comprehensive range of health conditions can respond better to the public health challenges of Europe in the 21st century than mono-profile teams organized around disease-specific silos. Expanding the scope of PHC services to incorporate a psychosocial approach that complements the biomedical model of care provision is a priority for the integration of mental health services and can help in addressing the social determinants of health more effectively. There is no single right way to assemble multidisciplinary teams; these can vary even within the same country depending on the composition of the population and its needs. Among the key professionals to be considered include (but are not limited to) general practitioners, nurses, midwives, mental health workers, social carers, social workers, physiotherapists, public health and community health practitioners, pharmacists and laboratory technicians.

10. Apply an integrated and networked approach for shared care pathways. Networked approaches can sustain a wider range of services with greater continuity across the full spectrum of care thanks to the possibility of sharing human and material resources. For example, the rotation of selected professionals, such as mental health specialists or physiotherapists, across smaller PHC practices can facilitate access to more comprehensive infrastructure and enable a more flexible approach to workforce deployment, whereby teams can be easily reinforced when required. Evidence-based shared care pathways for complex conditions are critical to the integrated and networked delivery of PHC and to defining the roles and responsibilities of the various team members. This is particularly relevant to efforts to respond more effectively to the closely linked health and social needs of an ageing population.

11. Bring services closer to people. The pandemic has highlighted the importance of alternative modalities for the delivery of health services, and it has also accelerated the trend of taking services to people rather than the other way around. This is particularly important in the case of remote areas (such as rural or mountainous areas and islands), where nearly twice
as many difficulties in accessing quality health and social services are reported by people as in urban areas. Digital solutions combined with innovative methods of service delivery, such as mobile teams, have tremendous potential to improve rural and remote communities’ access to health care in a timely manner. By carefully combining virtual and face-to-face consultations based on proper prioritization of cases and by taking digital literacy and other personal factors into account, the reach of health services can be extended without having to sacrifice quality of care. Multidisciplinary, integrated teams remain instrumental in the delivery of mobile and digital services, and new approaches and know-how need to be developed and tested. A particularly important paradigm shift to consider is the delivery of health and social services for older people in their own homes, rather than in institutionalized settings with both a medical and social component.

**Protecting against health emergencies**

**Operating dual-track PHC services safely during emergencies**

12. Contribute to the emergency response through PHC. Well-prepared PHC services, clearly linked to the public health service, can contribute significantly to an emergency response. Such services may include supporting surveillance efforts, engaging in testing and contact tracing, managing mild and moderate cases on the basis of adequate clinical guidelines and training, providing rehabilitation services, protecting the vulnerable through regular contact and tailored service delivery mechanisms, and providing surge health workforce capacity in other areas of the health system. Most European countries could benefit from strengthening these functions in the post-pandemic period to enhance monitoring and preparedness for potential future emergencies.

13. Maintain essential health services in PHC settings during emergencies, with clear identification of vulnerable populations. Many countries in the European Region have reported severe disruptions to essential health services that could have a significant public health impact, such as preventive services; screening for cancer; early detection and proactive management of cardiovascular conditions, diabetes and tuberculosis; and timely treatment for time-sensitive acute conditions such as heart attack and stroke. Creating separate patient flows and establishing infection prevention and control practices have been instrumental in ensuring the safe delivery of face-to-face PHC services during the pandemic. Moving to consultations via telephone, video calls and automated platforms has allowed remote delivery of services. Setting up triage mechanisms and activating population health management tools help to prioritize resources for the most vulnerable. Mitigating the health impact of disruptions requires clear priority-setting to ensure the best use of resources. During emergencies it is tempting to follow the emergency response closely while paying less attention to disruptions to other services. A dual dashboard displaying the values of key indicators that can be used to monitor both aspects could help to overcome this challenge.

**Promoting health and well-being**

**Strengthening solidarity in the pursuit of health and well-being through an integrated approach that builds on partnerships**

14. Move away from siloed approaches in the promotion of health and well-being. Health, the broader notions of well-being, and economic growth are interdependent and mutually
reinforcing. Health equity and well-being must be at the heart of Europe’s social and economic recovery from the pandemic. To drive change that can meaningfully improve health, health equity and well-being, PHC teams must be better positioned to address the upstream determinants of health. This requires alignment of population-level interventions with individual services in order to address the priority health and social needs of the population. This requires a shift in PHC services from a focus on diseases towards maintaining health, health equity and well-being. In practical terms, this means greater integration of psychosocial approaches with the more traditional biomedical approach as part of a holistic strategy. Moreover, institutional connections between PHC teams and organizations delivering and coordinating public health and social services need to be strengthened. Integration between PHC and public health services can facilitate health promotion, prevention, early detection and service provision to at-risk populations. Closer integration between PHC and social care enables the health system to address a wide range of health determinants. Thus, stronger PHC will play an important role in efforts made by the WHO Regional Office for Europe (WHO/Europe) related to the economy of well-being and to bringing about an equitable post-pandemic recovery.

15. Identify and reach the vulnerable early on. The pandemic has magnified the practical obstacles that countries encounter in reaching the vulnerable: missing, incomplete or outdated definitions of vulnerability that are disease-centric rather than holistic; lack of a population register and methodology at the PHC level to classify people into various groups of vulnerability; and lack of updated records for reaching the vulnerable. These obstacles can be overcome by developing a definition of vulnerability that considers both health and social determinants; adopting a mechanism to stratify the population according to risk; connecting this risk stratification with updated enrolment databases in order to be able to contact people in real time; and, where possible, linking to hospital and other data sources. In the digital age, investing in these tools can make a significant difference to the lives of those who truly need assistance.

16. Engage civil society in united action for solidarity. Working with civil society is an important strategy for creating partnerships and reorienting health systems towards solidarity in the quest for better overall health and well-being. Diverse and thriving civil society participation in health care can help to balance interests via policy advocacy; facilitate the participation of the most vulnerable people and communities in policy design, implementation and monitoring; and deliver services beyond the reach of mainstream health service delivery arrangements. The greater engagement of civil society in the delivery of public services fosters community spirit, thereby building trust and increasing the accountability of governments to the public.

Making it happen: a comprehensive and aligned health system approach

17. High-level political commitment is needed to place PHC at the centre of a strategy for equitable social and economic recovery in the post-pandemic period.

18. Achieving this ambitious goal of transformation of the PHC model will require firmly anchoring PHC within a comprehensive approach to the strengthening of health systems. In particular, it is necessary to do the following:

• Review governance arrangements at the national and subnational levels to ensure that they are well defined; explore the possibility of, and the potential benefits of, establishing multidisciplinary PHC taskforces with a clear mandate to develop
policy frameworks; facilitate the implementation of change and sustain innovations that have been proven to work; and monitor progress.

- Invest in health as a driver of an equitable social and economic recovery, which means prioritizing public health and PHC services in the health budget. This will ensure that comprehensive PHC services are available free of charge and will expand coverage of the costs of outpatient medicines for PHC-sensitive conditions, which are the main cause of catastrophic and impoverishing payments for households in the Region.

- Address the critical shortfall in the health and care workforce, with a focus on attracting, protecting and retaining health and care workers by enhancing labour market policies; carrying out long-term planning of health workforce and competency needs on the basis of health priorities; rethinking financial and non-financial incentives; providing attractive and safe working environments; and offering health and well-being support and monitoring for health workers – all building on the momentum generated by the designation of 2021 as the International Year of Health and Care Workers.\(^3\,4\)

- Ensure comprehensive training and specialization in family medicine to strengthen clinical and non-clinical competences such as focusing on patients’ needs, continuity, coordination of care, teamwork and interpersonal communication.

- Enable greater autonomy and task shifting for nurses by revising their scope of practice, providing multidisciplinary training and redefining roles and responsibilities within teams.

- Invest in infrastructure development and renewal to ensure that PHC facilities provide a dignified setting in which to seek care, are attractive workplaces and can support multidisciplinary team-based engagement – for the delivery not only of biomedical services but also of psychosocial services.

- Accelerate the uptake of digital solutions for consultations and communication between health professionals by establishing clear regulatory frameworks, providing adequate clinical decision support (for example, through guidelines, decision aids and training) and taking account of the digital divide when prioritizing face-to-face consultations.

- Continue to integrate data and support multidisciplinary teamwork with interprofessional health records.

- Create stronger financial incentives for services to be provided in PHC settings and financially reward the delivery of health promotion, prevention, early detection, team-based disease and condition management, and rehabilitation services for PHC-amenable conditions, while simultaneously reducing incentives to access such services at the specialist and/or hospital levels.

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• Foster organizational development by integrating stand-alone facilities into networks (to improve resource sharing and agility), ensuring the autonomy of service providers, and expanding professional health management capacities and skills. This will lead to more complex multidisciplinary and networked organizations.

• Develop PHC performance monitoring, benchmarking and management in alignment with national policy frameworks and strategies by strengthening data collection mechanisms, setting up performance dashboards and benchmarks, and creating feedback loops so that any findings can be turned into action.

• Invest in national and cross-national research and engage in research networks to document alternative approaches to strengthening PHC during the pandemic and beyond, and evaluate their effectiveness.

PHC at the heart of the EPW

19. PHC cuts across the three core priorities of the EPW and is an excellent platform for advancing each of the EPW’s four flagship initiatives. WHO/Europe’s work programme on PHC focuses on pragmatic and actionable policy areas with a view to strengthening the contribution of PHC to the EPW’s three priorities and four flagship initiatives. Primary care is essential to the delivery of the mental health and immunization agendas featured in other working documents presented to the Regional Committee at its 71st session.5

20. WHO/Europe’s work programme on PHC is part of its overall health system strengthening strategy spearheaded by the WHO/Europe Division of Country Health Policies and Systems. Implementation of the programme is led by the WHO European Centre for Primary Health Care in Almaty, Kazakhstan. The Centre is an integral part of WHO/Europe and of the Division of Country Health Policies and Systems; its work programme is fully aligned with the EPW and the Division’s strategy and has harmonized implementation arrangements at the regional and country levels. Since PHC is central to the EPW, the Centre works in a coordinated manner with all of WHO/Europe’s divisions, programmes and geographically dispersed offices to develop specific joint products that can be implemented through agile delivery mechanisms and multidisciplinary teams.

21. The Centre also works closely with the newly established Special Programme on Primary Health Care at WHO headquarters. The Special Programme aims to (a) promote PHC renewal through policy leadership, advocacy and strategic partnerships, (b) produce PHC -oriented evidence and innovation, and (c) provide a one-stop mechanism for PHC implementation support to Member States, complementing the support provided by regional offices. WHO/Europe – through the Centre – contributes to European regional efforts to achieve all three objectives. Additionally, the Special Programme and the Centre are engaged in specific joint activities, such as the design of a new capacity-building programme on PHC.

5 The relevant working documents are: European Immunization Agenda 2030; The WHO European Framework for Action on Mental Health 2021–2025 and the new Mental Health Coalition; and Health system transformation in the digital age during the COVID-19 pandemic.
22. Contextualized country support for documented impact will be a focus of the work of the WHO European Centre for Primary Health Care under the EPW. In response to countries’ requests, the Centre will:

- support agenda setting and help to build political commitment;
- guide the establishment of effective governance arrangements for PHC and link these to the national public health service;
- engage in policy analysis and the evaluation of opportunities to realize the full potential of PHC;
- support strategic action through the development of policy frameworks and strategies;
- host tailored policy dialogue events and executive consultations for the objective review of evidence;
- provide implementation support and continued feedback on progress; and
- develop strong and actionable frameworks for PHC performance monitoring and management.

23. The Centre’s regional and global activities will support country engagement, seek to create a thriving regional network for peer-to-peer exchange, and share European experiences globally in order to emphasize the central role of PHC in achieving progress towards the Triple Billion targets. These activities include:

- regional and subregional dialogue platforms, virtual and face-to-face multi-country dialogues, and the regular webinar series “Let’s Talk Primary Health Care”;\(^6\)
- a series of policy papers containing pragmatic and actionable policy recommendations on key areas of interest in the strengthening of PHC;
- in-depth country profiles on PHC transformation;
- a series of short country vignettes on selected aspects of PHC transformation related to key policy themes;\(^7\)
- demonstration sites to show effective PHC in action;
- a pragmatic capacity-building programme on strengthening PHC in support of UHC, with both online and face-to-face learning (linked to the Pan-European Transformational Leadership Academy, the WHO Academy in Lyon, France, and WHO headquarters); and
- dedicated capacity-building and coaching on PHC performance management.

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\(^6\) The recording of the “Let’s Talk Primary Health Care” webinar series can be found at: https://www.youtube.com/watch?v=473Pt852EEY&list=PLL4_zLP7J_msQngass4GOrpMjao3NID8.

\(^7\) The PHC Country Vignettes series documents the transformation of PHC during the COVID-19 pandemic. Available at: https://www.euro.who.int/en/health-topics/Health-systems/primary-health-care/country-work/primary-health-care-country-vignettes.
**Measures of success**

24. While measures of success will be integrated into the monitoring and evaluation framework of the EPW, successful implementation of the proposed draft resolution would imply there is:

- an increase in the number of countries that have developed or revised policy frameworks and strategies on PHC, turning lessons learned from the pandemic into strategic action;

- an increase in the number of countries that have strengthened their governance arrangements for PHC and established a multilevel, multidisciplinary task force with a clear mandate that is regularly in touch with regional dialogue platforms and peer-to-peer networks for the exchange of experiences;

- an increase in the number of countries that have implemented fit-for-purpose and contextualized PHC performance monitoring and management approaches aligned with key strategic objectives; and

- an increase in the number of countries that are able to identify and reach at least 80% of their vulnerable populations in real time.