Towards a health-promoting primary care model in the WHO European Region

Intercountry retreat report
Bled, Slovenia, 26–28 February 2020
Abstract

The intercountry retreat held in Bled, Slovenia on 26–28 February 2020 aimed to create a learning space for professionals from both the public health service and primary care in Member States that are in the process of reforming primary care (Azerbaijan, Kyrgyzstan, Ukraine and Uzbekistan). Professionals worked hand in hand with each other, WHO representatives and invited experts toward designing a person-centred, health-promoting primary care model in their countries. They also identified system needs and specific steps required to obtain the support and resources necessary for capitalizing on the synergies between primary care and the public health service. The main theme that emerged was that primary care and the public health service – each with their own institutional identity – have complementary mandates and skills. Through the convergence and strengthening of primary care capacity for individual clinical care, on the one hand, and public health service capacity to provide population-level health promotion, disease prevention and health protection, on the other, health systems can achieve the best outcomes for the public’s health.

Keywords

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PRIMARY CARE
HEALTH PROMOTION
DISEASE PREVENTION
INTERGATION
REFORMS

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The cover photograph shows the participants of the retreat.
Towards a health-promoting primary care model in the WHO European Region

Intercountry retreat report
Bled, Slovenia, 26–28 February 2020
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The retreat programme was conceived, developed and delivered by: Anna Cichowska Myrup, Programme Manager, Public Health Services, and Martin Krayer von Krauss, Senior Advisor, Public Health Services, both WHO Regional Office for Europe; and Anne Madsen, Process Facilitator, Status Flow; with input from Zulfyja Pirova, Technical Officer, Health Service Delivery, WHO Centre for Primary Health Care, and Nurlan Algashov, Technical Officer, Public Health Services, WHO Regional Office for Europe.

The retreat was expertly facilitated by Anne Madsen, with Anna Cichowska Myrup acting as co-facilitator.

The report was written by Meggan Harris, independent science writer, who acted as the rapporteur for the retreat. Text editing was coordinated by Anna Cichowska Myrup, with editorial inputs from Luke Allen, general practitioner and Academic Clinical Fellow, University of Oxford, United Kingdom, and Pia Vracko.

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Executive summary

The intercountry retreat held in Bled, Slovenia on 26–28 February 2020 aimed to create a learning space for professionals from both the public health service and primary care in Member States that are in the process of reforming primary care (Azerbaijan, Kyrgyzstan, Ukraine and Uzbekistan). Professionals worked hand in hand with each other, WHO representatives and invited experts toward designing a person-centred, health-promoting primary care model in their countries. They also identified system needs and specific steps required to obtain the support and resources necessary for capitalizing on the synergies between primary care and the public health service.

The retreat followed a highly participatory methodology, derived from theories of change and emergence, to exemplify how professionals can effectively work together to implement a health-promoting primary care model. WHO organizers and a professional process facilitator guided group discussions on specific country needs, while Slovenian hosts showcased key features of their country’s primary care model to allow participants to visualize similar reforms in their own contexts. International experts participated as peers in the collaborative work, then offered insights based on their experience of how similar challenges had been addressed elsewhere.

Member States voiced numerous questions they had been grappling with in their efforts to improve primary care and (to a lesser extent) the public health service. Initial questions mostly were related to the best design for their primary care model, specifically with regard to the scope of services, evidence-based delivery, workforce development, finance, health information and hard governance tools (legislation, cooperation mechanisms and accountability). Over the course of the retreat, the conversations acquired greater depth and dimension as professionals gained shared clarity on the fundamental role of soft skills for engaging communities, negotiating with central policy-makers, and building the collegial relationships, trust and coalitions necessary to make change happen.

The main theme that emerged was that primary care and the public health service – each with their own institutional identity – have complementary mandates and skills. Through the convergence and strengthening of primary care capacity for individual clinical care, on the one hand, and public health service capacity to provide population-level health promotion, disease prevention and health protection, on the other, health systems can achieve the best outcomes for the public’s health.

The concluding part of the retreat gave each country delegation the opportunity to plan specific actions to expand the ability, authority and acceptability to enact reforms, while WHO representatives better understood how to support Member States by providing technical knowledge, practical tools, and opportunities for building skills, as well as by leveraging its convening power to advocate for population health at the highest tiers of government.
The purpose of the intercountry retreat in Bled, Slovenia (26–28 February 2020) was to create a learning space for professionals from public health services and primary care in Member States of the WHO European Region that are in the process of reforming primary health care (PHC) (Azerbaijan, Kyrgyzstan, Ukraine and Uzbekistan). With WHO guidance and process facilitation, these professionals worked with each other and with invited experts to design a person-centred health-promoting primary care model in their countries. They also identified system needs and specific steps required to obtain the support and resources necessary for capitalizing on the synergies between primary care and the public health service.

The rationale for this work stream resides in the demographic and epidemiological shifts that have taken place in European populations over the last decades, resulting in a high prevalence of chronic and noncommunicable diseases (NCDs), which in 2017 represented 82% of lost disability-adjusted life-years in the European Region (1). This disease burden imposes a high economic cost on Member States, not only in terms of direct government expenditure on health care, but also through indirect losses due to reduced productivity and premature mortality. These trends call for new health-system approaches, with a stronger focus on continuity of care, behavioural interventions and community engagement. By proactively tackling risk factors like smoking and diet at population and individual levels in primary care, health systems can help reduce the health impact – and control the costs – associated with treating unmanaged chronic disease in secondary and tertiary care settings (2).

World leaders reaffirmed their commitment to PHC in 2018 through the Declaration of Astana (3), which called for states to develop high-quality, safe, comprehensive, integrated, accessible, available and affordable PHC as the first level of care and the entry point to the health system for all populations, regardless of gender, disease or organ system affected. PHC is the whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities. Fully realizing this vision will require health systems to develop tools, skills and types of health workers capable of addressing complex problems in a multidisciplinary and holistic manner. In fact, many of these resources already exist within public health services, whose mandate and functions overlap and complement those of primary care (Fig. 1).
Participating Member States were Azerbaijan, Kyrgyzstan, Ukraine and Uzbekistan. Broadly speaking, the roots of the Semashko and Sanepid systems are still quite strong in these countries: people's entry point to the health system is through polyclinics staffed by a range of secondary-level specialists, while the role of primary care physicians or general practitioners (GPs) (where this position exists at all) frequently is limited to administering a few specific services (such as vaccinations, and maternal and child health services). As another legacy of the Sanepid model, quality control tends to depend on levers related to incentives and sanctions. In addition, chronic resource shortages, both financial and human, are creating challenges in meeting unmet health service needs.

These circumstances reflect the need for a holistic approach to strengthening primary care, taking into account the WHO health-system building blocks, the Essential Public Health Operations (5) and the Declaration of Astana. According to this framework, the health workforce, information system, access to essential medicines, financing, and leadership and governance all work to support effective service delivery that is capable of meeting overall health-system goals (6) (Fig. 2).
The aims of the retreat were twofold.

First, the event explicitly aimed to bring together representatives from both primary care and the public health service, including staff from the WHO Regional Office for Europe and WHO country offices, representatives from Member States, and international experts and researchers, to consider questions related to:

- implementing an integrated primary care service model
- mapping system and institutional capacities to support implementation
- identifying actionable steps to ensure the effectiveness and sustainability of reforms.

High-quality primary care service delivery therefore requires: skilled professionals to attend patients; a health information system to monitor trends, streamline care pathways and inform policy decisions and service design; good access to health technologies and medicines; sufficient funding to meet both routine and emergency needs; and rigorous governance and leadership to manage interactions between different areas of the system.

All participating countries are either undertaking, or on the cusp of reforming, their primary care and/or public health service. Government commitments to these efforts vary, and while not all of the Member States have secured sustainable investment streams or have formalized national strategies, all have expressed support for strengthening PHC.

Annexes 1 and 2 present the event programme and list of participants.
Secondly, there were implicit aims from the WHO perspective that the retreat should provide an opportunity to identify the needs of Member States as they design and refine their primary care models to encompass public health principles. There was interest in defining needs that WHO can assist with immediately and those requiring further research.

Expected outcomes were to:

1. provide inspiration and examples of activities and policies already in place across the countries of the European Region in relation to integrating public health and primary care services;
2. share clarity on how public health and primary care communities at ministry of health and other levels of the health system could work together when designing and implementing PHC reforms and new models of primary care;
3. share clarity on the system needs and institutional capacities that are necessary to support implementation of new health-promotion and disease-prevention services;
4. develop a list of the emerging policy questions related to integrating public health and primary care services; and
5. gain practical experience with participatory methods and collaboration practices.
PARTICIPATORY METHODS FOR COLLABORATION AND CONVERGENCE

Key points

- The 2.5-day retreat in Bled, Slovenia used participatory approaches derived from theory of change and emergence to exemplify how professionals can effectively work together to implement a health-promoting primary care model.
- Organizers and participants played specific roles intended to maximize learning opportunities:
  - WHO organizers framed the topics discussed during the group work;
  - a process facilitator ensured structured, constructive conversations; and
  - Slovenian hosts showcased their country’s primary care model, allowing Member States to visualize similar reforms in their contexts.
- Member State representatives worked together toward a shared understanding of the challenges and opportunities for allying public health and primary care approaches, applying concrete, co-created solutions to their plans going forward.
- International experts practiced deep listening to learn how so-called wicked problems were manifesting in different settings and shared experiences on how they had been addressed elsewhere.

The retreat used participatory methods, drawing concepts from theory of change (7), asset-based approaches (8) and emergence (9) and applying them to complex adaptive systems like health systems.

Briefly, theory of change is concerned with understanding how and why different interventions work. It articulates stages of development based on stakeholder consensus, critical analysis of contextual circumstances and identification of all available assets. In a similar vein, asset-based approaches – sometimes referred to as a head, hand and heart approach – aim to mobilize knowledge- (head), skills- (hands) and values-based (heart) resources in the pursuit of a shared goal. Emergence explores the dynamics of networks – why they form, how they stay alive and grow, what kind of leadership strengthens (or weakens) them, and how to nurture participatory leadership among its members. When applied to health-systems interventions, these approaches work to foster a shared clarity about problems impeding progress and enable the co-creation of solutions to tackle them.

Some people view [theory of change] as a tool and methodology to map out the logical sequence of an initiative from inputs to outcomes. Other people see it as a deeper reflective process and dialogue amongst colleagues and stakeholders, reflecting on the values, world views and philosophies of change that make more explicit people’s underlying assumptions of how and why change might happen as an outcome of the initiative.

Vogel (7: p.16)
The intercountry retreat in Bled applied these theories to practice using a series of participatory activities, applying methodologies developed and promoted through the Art of Hosting network (10). WHO representatives framed the topic discussions, highlighting current issues and international perspectives and experiences addressing them. A process facilitator then led participants through semi-structured conversations around the meaning of integration of primary care and public health services, what form it could take in their countries, what resources are required, and what practical steps could be taken to obtain them. These conversations were witnessed by WHO representatives and international experts, who offered brief meta-reflections on common themes, pointed retreat participants to existing evidence, and listened for emerging questions and Member State needs. In addition, field visits were organized to two primary care centres in Slovenia, one in Ljubljana and one in Kranj, to show Member State representatives how health-promoting primary care works in practice.

The participatory methods ... allowed us to systematize our approach and put everything that we were missing into one puzzle ... the facilitator helped to avoid unstructured [talk] and maintain a more engaged learning process.

Roza Mukhamediyarova, Uzbekistan

The approach is very well done ... it is very good that we are not just sitting and listening in plenary, we have the opportunity to think and discuss.

Tolkun Djamangulova, Kyrgyzstan
Framing and group work

Before opening group work discussions, organizers and the process facilitator presented technical concepts and highlighted the importance of open dialogue, relationships and trust in creating resilient and adaptive systems.

Anna Cichowska Myrup from the WHO Regional Office for Europe discusses the natural synergies and overlaps between public health and primary care.

Volodymyr Lotushko explains the progress Ukraine is making and the obstacles it is encountering in the development of their primary care and public health systems. This process highlighted the common challenges Member States face on the road to reform.

It was really important for me to know that we can do [PHC reform] in different ways.

Dinar Gahramanova, Azerbaijan
Collaborative story harvest

On day 1, participants listened to Pia Vracko from Slovenia’s National Institute of Public Health as she described PHC development in the country, extracting key themes through four listening lenses: collaboration, leadership, timing and managing change.

**Collaboration lens**

- Decision-making initiatives came from multiple levels, from practitioners to national policymakers.
- Strategic partnerships, including with professional associations and international partners, facilitated progress at different stages of development.
- The establishment of professional chambers strengthened collaboration at interprofessional level.

**Leadership lens**

- Leadership was practised from the top down (for example, the Ministry of Health working to introduce registered nurses) but also from the bottom up (the Chamber of Family Medicine lobbying for legislation establishing the discipline as a specialty, for instance).
- Important political decisions were necessary in the transition from treatment-focused to prevention-focused care.

**Timing lens**

- Developing modern primary care took time – in the case of Slovenia, 30 years of negotiations and incremental advances.
- Different processes were launched concurrently, for example the introduction of registered nurses and the upgrading of health-promotion centres to include more comprehensive NCD services.
- Programmes were first piloted and then rolled out at a wider level.

**Managing change lens**

- Developing PHC required a programme framework.
- The availability of sustainable financing and political commitment conditioned the pace and scope of reform.
- Professional training and tools facilitated change.
- Effective quality-monitoring programmes and pilots ensured effectiveness and tracked outcomes.

**PHC reform in Slovenia**

Over a period of nearly 30 years, primary care in Slovenia has gradually transformed from a reactive service providing episodic care to one that closely integrates NCD control, behavioural counselling and epidemiological data analysis into the service model. Key milestones included the creation of the Chamber of Family Medicine at the Medical Faculty of the University of Ljubljana in 1995, which, together with the Slovene Family Medicine Society, GPs and international partners, helped drive the movement to formally establish the family medicine specialty.

Around the same time, in 1991, the first health-promotion centre within primary care centres were established, following the WHO CINDI model (11). Training was offered on a voluntary basis to professionals, while community members could access services like cardiovascular risk screening. After 11 years of experience and political negotiations, full funding was ensured for the programme countrywide through the Health Insurance Fund.

From 2000, several national public health strategies were put into place, including on food and nutrition, alcohol and tobacco, diabetes and cancer. These policies supported the presence of promotion and prevention services within primary care centres.

Quality improved thanks to investments in training – notably, the gradual incorporation of registered nurses for NCD counselling, screening and management in all primary care centres starting in 2011 on the initiative of the Ministry of Health – and the introduction of clinical protocols, established in collaboration with family medicine specialists, secondary care specialists, nurses and public health practitioners.

Between 2014 and 2020, international partnerships helped use the Norwegian Financial Mechanism and European Structural Funds to further upgrade health-promotion centres, enabling the incorporation of more comprehensive, multidisciplinary and proactive care, including stronger community outreach to tackle health inequalities and the social determinants of health.
Field visits to primary care centres in Slovenia

On day 2, participants split up to visit two primary care centres in Slovenia to see first-hand what integration of primary care and public health services could look like. In Ljubljana, participants heard about the introduction of a registered nurse into a family medicine team to run services related to NCD prevention and control, and saw a simulation centre where both health-care professionals and interested members of the lay public (such as teachers and firefighters) can receive training in emergency first response. In Kranj, visitors learned about health-promotion centres that deliver group workshops to support people in adopting healthy lifestyles, and about how Slovenia uses the health information system to tailor primary care services to population needs. They also had the chance to sample the kinesiology service – one activity offered in the health-promotion centres – for themselves.

We saw how it can work in real life. We saw the relationships in the community centre. We saw their structure and their electronic systems.
Volodymyr Lotushko, Ukraine

Visual templates – posters were used to guide group discussions and capture their collective responses to discussion points and then displayed around the venue for the duration of the retreat.

Day 2 topics elicited ideas on the kinds of health-promoting primary care services participants would like to see in their countries, how the public health community could contribute, and what kind of questions were emerging about how to realize their objectives.
Deep listening and meta-reflections

Throughout the retreat, invited experts specializing in a range of topics related to primary care or public health practised deep listening in the group work, probing details about country challenges and offering observations based on their research and professional experience.

Some of the processes which created collective voice were very helpful in taking very disparate views and experiences, turning them into something that we could then provide a lens from experience on.

John O’Dowd, United Kingdom
my country

* Funding model in place
* Other transition

with the good
EMERGING QUESTIONS ON THE ROAD TO MODERNIZING PRIMARY CARE AND PUBLIC HEALTH SERVICES

Key points

- Member States and invited experts raised numerous questions related to developing modern health-promoting primary care services.
- Initial sessions brought to light countries’ technical needs as they worked to design system characteristics such as gatekeeping mechanisms, financial incentives and quality-assurance indicators.
- As the retreat progressed, the dialogue turned to questions about less tangible aspects of health-systems strengthening, such as strengthening skills in participatory leadership, coalition-building, negotiation and trust between stakeholders.

Member State participants arrived in Bled with enthusiasm and a keen desire to learn, as each country was grappling with how to overcome deep-rooted structural barriers hindering primary care and public health service development.

Because these services often were not well established, participants had little first-hand experience of what modern primary care and public health services look like and how they work in practice. Logically, then, initial questions predominantly were technical in nature and mostly related to the best design for their primary care model. Over the course of the retreat, however, the conversations acquired depth and dimension as professionals gained shared clarity on the fundamental role of soft skills for engaging communities, negotiating with central policy-makers, and building the collegial relationships and trust necessary to create change.

Technical questions

Table 1 presents a summary of the main technical questions raised during the retreat, including those explicitly articulated by Member State representatives, the unspoken questions discerned by invited experts, and questions arising during conversations between Member State participants, experts and WHO representatives.

The focus of the event was on how to implement a health-promoting primary care model – that is, how to deliver primary care services that take into account the traditional public health operations of disease prevention, health promotion and health protection. The questions that emerged illustrate the prematurity of considering how to integrate primary care and public health services in settings where these two distinct systems have yet to be firmly established in their own right.

In addition to questions related to service delivery, participants had numerous queries about enabling operations rooted in health-systems strengthening. Among them were questions related to human and financial resource shortages, quality assurance, evaluation systems and provider incentives.
Table 1. Technical questions emerging from dialogues about developing health-promoting primary care services

<table>
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<th>Domain</th>
<th>Questions</th>
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<tr>
<td><strong>Questions relating mainly to PHC</strong></td>
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<tr>
<td><strong>Scope</strong></td>
<td>- What is primary (health) care?</td>
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<td>- What services should be delivered in primary care?</td>
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<td></td>
<td>- What’s the difference between a polyclinic and a primary care centre?</td>
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<td></td>
<td>- How can the medicalization of primary care be avoided?</td>
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<td></td>
<td>- How can systems integrate both individual- and community-level services?</td>
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<td></td>
<td>- To what extent have health-policy discussions considered the full spectrum of services needed for primary care to thrive?</td>
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<td><strong>Evidence-based delivery</strong></td>
<td>- How can gatekeeping be introduced in primary care?</td>
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<td>- What’s the international experience about developing clinical protocols for primary care?</td>
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<td></td>
<td>- What’s the international evidence on state-guaranteed services?</td>
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<td><strong>Workforce</strong></td>
<td>- What medical specialists operate in primary care?</td>
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<td>- What’s the family physician’s scope of practice?</td>
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<td></td>
<td>- How can training be reoriented toward prevention?</td>
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<td></td>
<td>- As more tasks are delegated to nurses, how can we retrain nurses and physicians?</td>
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<td></td>
<td>- What does a multidisciplinary primary care team look like and how does it work?</td>
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<tr>
<td><strong>Questions relating mainly to public health and health systems</strong></td>
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<tr>
<td><strong>Scope</strong></td>
<td>- What are public health services?</td>
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<tr>
<td><strong>Finance</strong></td>
<td>- How can public health services be financed?</td>
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<td>- How can systems incentivize primary care doctors to provide the best and most cost-effective care?</td>
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<td>- What’s the evidence on capitation-based and fee-for-service purchasing mechanisms?</td>
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<td>- How can we design outcomes-based payments?</td>
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<td><strong>Health information</strong></td>
<td>- How can we create a system for health-data and health-services collection (and support), reporting and monitoring?</td>
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<td></td>
<td>- How can these data be used for continuous quality and performance improvement?</td>
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<td>- How can health data be used to drive improvements and plan services?</td>
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<td></td>
<td>- Who has ownership over the data in community health profiles?</td>
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<tr>
<td><strong>Governance</strong></td>
<td>- What quality and performance indicators can be used for evaluating primary care and public health services?</td>
</tr>
<tr>
<td></td>
<td>- What coordination mechanisms exist for integrating primary care and public health services?</td>
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</tbody>
</table>
The variety and specificity of the questions was largely a function of where Member States were in their reform journey. Countries that were still designing their primary care and/or public health service (such as Azerbaijan and Kyrgyzstan) wanted to understand aspects like the typical scope of practice for GPs, or how to implement a gatekeeping system. Professionals from other countries, such as Ukraine, which already has established strong foundations for modern primary care services nationwide, were interested in quality-assurance mechanisms, developing a workforce with a proper skills-mix and establishing the right financial model. All countries showed a keen interest in creating the right incentives for professionals, building the capacity of their primary care workforce, and establishing quality-assurance systems.

We had an opportunity to discuss our issues with different experts from different areas of specialization. From one side, we had people who helped us with the government and management system and the health monitoring and indicators. We had experts on human resources for health to discuss capacity-building and accreditation ...

Roza Mukhamediyarova, Uzbekistan

As the retreat unfolded, however, and especially after the field visits to the primary care centres in Ljubljana and Kranj, there was a clear shift in the kinds of questions being asked. The top concerns were no longer the two-dimensional design issues – that is, what an effective primary care system looks like on paper. Rather, the third, human, dimension came into focus, as participants began to ask themselves and each other how similar services could be established in their own countries. At the crux of these questions was the need to develop soft governance skills and nurture relationships among stakeholders.
Skills-related questions

Table 2 presents the skills-related questions that occupied participants at the retreat. At the top of Member States’ minds from the beginning of the retreat was how to build trust in primary care among populations that traditionally have associated secondary and tertiary care with higher quality. This line of inquiry opened the door to deeper discussions throughout the retreat around strengthening professional alliances, organizing platforms for community engagement, overcoming resistance to change (not only among populations, but also in professional and decision-making groups) and utilizing softer governance skills – generally more associated with the public health sphere – to strengthen the quality of care provided in clinical settings.

Table 2. Skills-related questions emerging from dialogues about developing health-promoting primary care services

<table>
<thead>
<tr>
<th>Domain</th>
<th>Questions</th>
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<tbody>
<tr>
<td>Trust and engagement</td>
<td>- What should incentivize people to use primary care instead of hospitals?</td>
</tr>
<tr>
<td></td>
<td>- How can we increase people's trust in primary care?</td>
</tr>
<tr>
<td></td>
<td>- What are the rules for how the system will work in each country?</td>
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<tr>
<td></td>
<td>- How will health authorities know what their communities need?</td>
</tr>
<tr>
<td></td>
<td>- How can we organize platforms for engaging communities?</td>
</tr>
<tr>
<td></td>
<td>- What is most important to patients?</td>
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<td></td>
<td>- How do these priorities differ from priorities for population health?</td>
</tr>
<tr>
<td>Managing change</td>
<td>- How can systems with a large number of narrow specialists but poorly</td>
</tr>
<tr>
<td></td>
<td>trained GPs make the transition to a system with well trained family</td>
</tr>
<tr>
<td></td>
<td>physicians and introduce primary care as an obligatory entry point in</td>
</tr>
<tr>
<td></td>
<td>which a wide array of basic health needs can be met?</td>
</tr>
<tr>
<td></td>
<td>- How do we overcome resistance to change in different groups (citizens,</td>
</tr>
<tr>
<td></td>
<td>professionals and policy-makers)?</td>
</tr>
<tr>
<td></td>
<td>- How can we secure sustainable funding and political commitment?</td>
</tr>
<tr>
<td></td>
<td>- How do you motivate professionals to drive change?</td>
</tr>
<tr>
<td></td>
<td>- How can we identify change agents?</td>
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<tr>
<td></td>
<td>- How can professionals formulate arguments for health-system strengthening</td>
</tr>
<tr>
<td></td>
<td>that convince policy-makers and build political commitment?</td>
</tr>
<tr>
<td></td>
<td>- What do we need from WHO and other international organizations?</td>
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<td></td>
<td>- How can systems translate the successes achieved in the area of</td>
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<td></td>
<td>immunizations to other areas, like NCDs?</td>
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<tr>
<td>Collaboration</td>
<td>- How do you involve other partners?</td>
</tr>
<tr>
<td></td>
<td>- How can we create and strengthen partnerships between different</td>
</tr>
<tr>
<td></td>
<td>professional groups?</td>
</tr>
<tr>
<td></td>
<td>- What kinds of links are necessary between public health, primary care</td>
</tr>
<tr>
<td></td>
<td>and communities?</td>
</tr>
<tr>
<td></td>
<td>- How can we form a multisectoral expert group?</td>
</tr>
<tr>
<td>Workforce skills</td>
<td>- What skills are required for public health, and how can public health</td>
</tr>
<tr>
<td></td>
<td>professionals acquire them?</td>
</tr>
<tr>
<td></td>
<td>- What motivation do primary care physicians and other professionals need</td>
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<td></td>
<td>to perform preventive services?</td>
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</tbody>
</table>
The retreat programme was designed to promote Member State reflections on how interpersonal dynamics and professional culture can catalyse, nurture or hinder change. For example, the storytelling activity on day 1 elicited observations around leadership, collaboration, change management and timing. This session was valuable on its own, but it also set the stage for the field visits on the morning of day 2, where participants were able to see how these concepts worked in practice.

Upon their return to Bled, participants worked together to envision similar services in their own countries and identify how the public health community could contribute to strengthening primary care. Similarly, the participatory nature of the group discussions exemplified how to build some of the soft power that Member States considered necessary to achieve their goals, such as motivating professionals to drive change or creating partnerships between groups.

“Sometimes it’s difficult to change ... The first day it was impossible, but now ... [we’ve] learned to listen.”
Tolkun Djamangulova, Kyrgyzstan

Member States identified a number of specific competencies they considered necessary to bring about change. They expressed a need to develop negotiating skills, for example, to secure the commitment of the central government or the ministry of finance to support health-systems strengthening sustainably. Clarity also emerged on the usefulness of stakeholder analysis for understanding what each stakeholder wants to achieve and has to offer, and what they oppose. At the same time, horizontal leadership was seen as a skill that would enable shifts in power dynamics, creating space for meaningful contributions from all partners, including change agents who cannot effectively be mobilized through hierarchical power structures.

Throughout the retreat, questions were raised around community engagement: how this could be organized, what rules should govern it, and how health professionals can open dialogues with community members to understand what they need. Participants came to recognize that preventive services required health professionals to develop a different skills-set based on trust and responsiveness, and motivation stemming from non-financial incentives.

Finally, data analysis was seen as an important but underdeveloped skill that could allow primary care to tailor services to population needs and ensure good quality and performance of these services.

“It was really helpful to visit Ljubljana’s health-care system ... It’s close to our polyclinics, but something different, you know, the relationships are different ... something more.”
Dinar Gahramanova, Azerbaijan
META-REFLECTIONS AND KEY THEMES

During their interventions over the course of the retreat, the international experts addressed many of the questions raised and provided references for others (see annotated bibliography in Annex 3). The experts actively participated in the groupwork sessions, applying their own experiences to the challenges Member States were facing. They also put together a joint presentation on day 3 that synthesized the main areas of discussion during the retreat: the scope of primary care; needs assessment and planning; governance and finance; and workforce, change management and skills.

With regard to the scope of primary care, Salman Rawaf and Pia Vracko made a strong case for primary care as the first contact for care, providing services that are holistic, personalized, undifferentiated, comprehensive and unconditional – principles first enshrined in the Alma-Ata Declaration and recently reaffirmed in Astana (3).

Economic arguments were presented showing that proactive, preventive care in primary care costs a fraction of reactive, curative care in hospitals. At the same time, presenters called for a health model centred on providing all people with continuous individual care and health-promotion interventions. Ultimately, the status of primary care should be on a par with other medical specialties, constituting the first point of contact with the health-care system and delivering appropriate, continuous care throughout the life-course.

From the countries, I learned that despite where they are on their development, the problems they face are actually very similar to the problems that are faced in the countries where I normally work.

John O’Dowd, United Kingdom
Luke Allen then discussed needs assessment and planning, urging planners, administrators and practitioners to consider the particularities of each community and make efforts to understand not only what people may need (such as smoking-cessation services) but also what they want (afternoon opening hours, for instance). To better attune primary care services to local contexts, they must connect with other organizations and patients. Measures to facilitate such links might include housing public health and primary care services under the same roof, setting up regular meetings, establishing patient groups or performing household surveys. Fluid relationships and clearly defined responsibilities allow different kinds of professionals to use their diverse skills in complementary ways to, for example, apply data analysis to the creation of community health profiles, which in turn can inform service planning.

In terms of governance and financing, John O’Dowd observed that governance relies on people’s trust, with implications for both hard governance (institutions, rule of law and the registration system) and soft governance (personal relationships, kept promises and transparency). Each of the main financing systems (capitation, salary and fee-for-service) can create misaligned incentives if used alone, so most systems in Europe opt for a mixed form of financing to provide balance (12). For example, integrated capitation funnels payments for secondary and tertiary services through primary care to favour continuity of care and coordination. Achieving the right mix between different incentives – including those that are non-financial – is complex and requires continuous calibration and access to health intelligence. This kind of guidance is often concentrated within the public health sector.

Finally, issues around the workforce, change management and skills were presented by Beccy Baird and Mehmet Ungan. Dr Ungan reflected on the complexity of primary care practice, where patients present with a much wider range of conditions than in specialist care. While just five diagnoses are responsible for 90% of visits to secondary specialists, the most common 25 diagnoses account for 60% of visits in primary care (13). This complexity underlines the need for highly trained family physicians and nurses who achieve the core competencies for primary care (14). Dr Baird noted, however, that medical professionals need not work alone. Rather, primary care teams can include a much wider health workforce that includes specialists like dieticians and physiotherapists or non-professionals such as health coaches and community health workers.

The plenary presentation also captured a cross-cutting theme that emerged from the retreat: skills traditionally associated with public health are crucial for strengthening primary care. Fig. 3 presents some examples of how this works in practice, providing illustrative examples of how primary care and the public health service complement each other in the pursuit of a common goal: better population health.
People need a wide range of services across the life-course, from neonatal care at birth to chronic disease management in old age. These services are delivered in primary care settings, where a team of professionals should work together to build trusting, open relationships with the communities they serve, manage complex and interacting health determinants in individuals, and provide appropriate, acceptable and responsive care, including through fluid coordination with other health-care and social services.

In practice, primary care teams encounter multiple challenges to community health, such as poor nutrition, low health literacy, a rising burden of chronic diseases and environmental exposure to health risks, that cannot effectively be addressed at service-delivery level. It is in these areas that public health can best support primary care: public health statisticians can analyse health data to inform planning, legal experts can draft legislation and standards for health protection, communication campaigns can empower people to change behaviours and engage proactively with the health service, and policy strategists can develop intersectoral plans to tackle health determinants at societal level.

The National Institute of Public Health of Slovenia exemplifies how such support can work in the real world. In its role as steward of the health information system, the institute develops and publishes health and health-system performance indicators and collects and analyses data from national to municipal level. It also performs surveys on health-related behaviours, develops tools to support NCD services (questionnaires, education programmes and training courses), monitors the delivery of health-promotion and disease-prevention programmes, and collaborates with primary care, the Ministry of Health and scientific societies to improve performance. Finally, the Institute negotiates with the Health Insurance Fund, ensuring sustainable funding of programmes and services.

[The retreat helped us understand] that we have big potential to integrate our two systems in one ... prevention is the best choice for our population and our economy.

Volodymyr Lotushko, Ukraine
On the final day of the retreat, participants reflected on how they could expand the space needed for developing their health systems, completing a visual template adapted from Andrews (16) (Fig. 4). After brainstorming on steps to increase the ability, acceptance and authority needed for enacting reforms in their countries, they consolidated their ideas into digital files, setting out concrete steps they could take upon their return.

**Key points**
- Member States left Bled with a list of concrete steps they planned to take upon their return home to reorient their primary care services towards a more comprehensive, proactive and health-promoting model.
- Specific plans included the creation of multisectoral working groups to coordinate strategy, the development of health information systems to support policy-making, and the establishment of family medicine training for physicians, nurses and other providers.
- WHO can support this work by organizing training courses, curating resources to assist Member States with specific programmes, building skills for stronger professional networks and using its convening power to advocate for health reforms among decision-makers.

On the final day of the retreat, participants reflected on how they could expand the space needed for developing their health systems, completing a visual template adapted from Andrews (16) (Fig. 4). After brainstorming on steps to increase the ability, acceptance and authority needed for enacting reforms in their countries, they consolidated their ideas into digital files, setting out concrete steps they could take upon their return.

**Fig. 4. Increasing the reform space for successful implementation of reforms**

- Evaluation ability
- Human resource ability
- Technology ability
- Political
- Managerial
- Incentive compatibility
- Legal
- Procedural
- Organizational

Source: adapted from Andrews (16).
Next steps for developing primary care and public health services in Member States

For the past several years, Azerbaijan has been focusing on the introduction of mandatory health insurance, including through the creation of a new agency, the TABIB, to manage healthcare facilities and ensure the organization and delivery of health services for the population. For the Azerbaijan country delegation, the retreat in Bled served to highlight the need for more strategic thinking and planning. Representatives agreed to create a working group made up of professionals from the Ministry of Health, the Health Insurance Fund and the TABIB as well as universities, the ministries of education and finance, hospitals, parliament and the Cabinet of Ministers. This group will be tasked with developing action plans for the short and medium term to strengthen the health information system, family medicine training, and public health and primary care legislation. Coordination, support from central government and sustainable financing were considered essential for making the working group effective, and Azerbaijan will look to the international community to coordinate meetings, provide expert input and organize training courses and learning tours.

Professionals from Kyrgyzstan emerged from the retreat with ambitious ideas about how to build on and reorient their existing project concept for public health services. Participants agreed on the need to re-examine their programme plans with an eye toward fuller integration of primary care and public health services, paying close attention to the regulatory framework to ensure that national legislation supports their programme goals. They recognized the need to involve a wide range of stakeholders, including staff and national associations from both services, rural health committees, the Ministry of Health and the coordinating council for public health under the Kyrgyz Parliament.

Like their Azerbaijani counterparts, Kyrgyzstani participants plan to create an interagency working group to make recommendations on implementing health-system reforms. Drawing on the experience of Slovenia, where professional groups drove the development of primary care services, participants agreed on the need to strengthen professional associations and give them a stronger role in creating and implementing the health-service model. This endeavour includes the aspiration to establish a national institute of public health in the medium term. They will look to WHO and other international agencies for technical and training support, including for the design of effective monitoring and evaluation frameworks.

Representatives from Ukraine also left with concrete plans. Recognizing the momentum accumulated over the past several years of primary care and public health service reform in the country, participants were optimistic that the political context was favourable to building on the progress made thus far. The first steps will be to initiate a dialogue on advancing an integration agenda among the Ministry of Health, including the National Health Service and the Public Health Centre, and municipalities, regional authorities and national technical experts. This
process will include a discussion agenda to co-create a vision for integration of primary care and public health services, taking into consideration recent achievements in both sectors and areas where further development is still needed. In the medium term, different pilot projects are envisaged to test possible integration models. As for international assistance, Ukraine showed a desire for support in organizing, framing and facilitating stakeholder dialogues and in preparing international case studies in integration that could serve as a starting place for national consultations. Technical assistance was also sought in writing the conceptual note and roadmap.

Finally, the Uzbekistan delegation also put together a list of actions to take in both the short and medium term to develop their primary care and public health service. All action is to have a firm grounding in stakeholder participation, with inclusive dialogues with a wide range of actors, from local to national governing bodies, professional sectors and civil allies like the mass media. Together, contributors will develop a strategic vision and then work on implementation through a coordination council. Specific goals include a training programme for updating the competences of medical professionals, the development of normative documents on multisectoral working and the intersection between primary care and public health services (particularly with regard to finances), government guarantees on the inclusion of a public health financing strategy in the national budget, better knowledge translation through the appointment of national professional officers, the development of monitoring tools and outcomes assessments, the implementation of strategies to motivate staff and the digitalization of public health and healthcare data. WHO’s role in supporting this ambitious agenda includes assisting Uzbekistan in establishing a platform for multistakeholder consultation, developing normative documents for guaranteeing a service package, financing, designing, implementing and managing monitoring and evaluation instruments, and devising strategies to best motivate staff.
Leveraging international support for maximizing Member State achievements: the role of WHO in strengthening health-promoting primary care in the European Region

The retreat brought to light several areas where WHO could assist Member States that have committed to strengthening their primary care and public health service. Countries’ needs generally fall into four broad areas: knowledge, tools, skills and convening power.

Technical knowledge

First, the Bled retreat underlined an important rift in understanding with regard to what the public health and primary care service entail. Most Member State participants were not familiar with the Essential Public Health Operations (EPHOs), which articulate the Regional Office’s conception of public health services, nor were they acquainted with the international evidence about central concepts of modern primary care models such as gatekeeping mechanisms, different financial and purchasing models, workforce planning and development, quality and performance indicators, digital health information systems, or leadership and governance. Notwithstanding the potential political and cultural resistance to trusting family medicine practitioners to field all initial clinical consultations, there is a dearth of in-country technical expertise for managing the transformation of a health-care model based on polyclinics to one that hinges on primary care as the entry point to the health-care system.

WHO can provide support in building such technical knowledge through numerous approaches. Institutiona

lizing the celebration of flagship courses, like the one on public health policy and practice held in Kazakhstan in early February 2020 (17) and that planned for 2020 in Slovenia on reorienting and strengthening primary care, could provide policymakers, system managers and leading national experts with the opportunity to gain in-depth knowledge on the fundamentals of primary care and public health services, including how to align health services with the disease burden in the population. While the emerging COVID-19 pandemic has injected some uncertainty into the planning and preparation of such training courses, at least in the short term, it has also underscored their relevance. Pending the lifting of travel restrictions in the Region, online training courses such as WHO’s e-course on financing for universal health coverage (18) and other distance-learning initiatives like the WHO Academy (19) can help to fill knowledge gaps among a range of mid-career professionals.
A large quantity of practical resources, frameworks, toolkits and guidelines designed to assist countries in specific technical areas is already in place. WHO has toolkits on human resource development (20), digital health systems (21), modelling scenarios for NCD prevention (22) and social participation (23), among others, along with a self-assessment tool on EPHOs (24), a framework for integrated health-services delivery (25) and a draft operational framework for PHC (26). Meanwhile, the Disease Control Priorities Network, one of the many international organizations working to strengthen health systems worldwide, has published its third edition of cost-effectiveness reviews on essential packages of services in nine areas, including disease-control priorities for universal health coverage (27).

All of these tools are relevant to building and strengthening health-promoting primary care, helping to synthesize existing evidence and guide technical work and programme design. Their sheer volume, however, is probably overwhelming for most system managers working under great time and resource constraints. In that sense, the Regional Office can continue to supporting Member States to navigate the array of available resources, directing them to the most useful instruments for the programme at hand.
A major outcome of the retreat was the shared realization among all participants – Member State representatives, international experts and WHO officers – that achieving a health-promoting primary care model will not be possible without deploying specific non-clinical skills. Community engagement requires sensitive and multidirectional communication with different population groups, keeping in mind local power dynamics. Building political support for financial investments in primary care depends on smart evidence syntheses, good negotiating skills, and extended professional networks. High-quality care is partially a function of the right financial incentives for providers, but it is also the fruit of a working culture that values excellence as a goal in and of itself. The design and implementation of new programmes must draw from a deep bench of professionals, from statisticians capable of interpreting and synthesizing population health indicators, to public health and clinical experts who are familiar with evidence-based policies, to committed and energetic local actors who are empowered to tailor interventions to the needs of their communities.

Many of these skills typically are not associated with primary care but are core competences of public health practice, reinforcing the need for closer collaboration between the two areas. Unlike the knowledge-based needs, however, WHO has not yet developed all the resources and methodologies for equipping Member States with the foundation and capacities they need to lead their own PHC reform agendas.

Invited experts reflected on some of the questions they took with them as they left the retreat, including how to promote groups of professionals and unite them around a common cause, what features a toolkit for community governance would have, or how to manage the tension between international funders’ demands for quick outcomes and the real pace of changing working cultures and institutions. Other potential avenues for work include piloting integrated care centres in central Asian states by, for example, adding curative health services to the centres that currently offer only maternal and child health services, or creating common workspaces to promote a family medicine model.

For Member States, WHO’s power to convene diverse and high-level stakeholders constitutes a major asset, making WHO a valuable ally in country-led efforts to further develop health services. In addition to WHO support in building knowledge and skills capacities, this convening power can make the difference between building support around health priorities among technical professionals and using that support as a springboard for implementing national strategies sanctioned by top decision-makers.
CONCLUSIONS: EMERGING CLARITY ON THE NEED FOR A HOLISTIC APPROACH TO BUILDING MODERN PRIMARY CARE AND PUBLIC HEALTH SERVICES

In terms of the retreat’s outcomes, Member States produced a list of specific actions they would take to advance their primary care and public health service, which were co-created by public health and primary care professionals from participating countries. They demonstrated a greater awareness of the institutional capacities, systems-needs and soft governance skills that have to be developed to support implementation, and they gained experience in participatory working methods that can be applied in other contexts in their home countries.

Participants had been able to see the Slovenian model of health-promoting primary care and reflect openly on the role that professionals’ leadership, persistence and commitment had in modernizing health services. For their part, WHO officers from different divisions also had the opportunity to focus jointly on a shared objective, exploring synergies and creating new synapses between work streams. International experts left with new research questions to explore in their own work and increased clarity on the challenges common throughout the European Region.

The WHO working agenda for reorienting European primary care services towards prevention and health promotion involves:

• building a common understanding of the principles of modern primary care and public health practice through, for example, flagship courses, site visits and online learning exercises;
• helping Member States to identify and deploy the right technical-tools programme implementation;
• providing opportunities to use skills cultivated within the public health sector, such as communication, coalition-building, statistical and economic analyses, and policy development, to strengthen primary care; and
• taking full advantage of WHO’s unique convening power to support health professionals and authorities in creating deep and broad-based support for health-systems strengthening.
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1 All URLs accessed on 29 March 2021.


### RETREAT PROGRAMME

<table>
<thead>
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<th>Day 1. Wednesday 26 February</th>
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Annex 3.

ANNOTATED BIBLIOGRAPHY


Baird B, Chauhan K, Boyle P, Heller A (2020). How to build effective teams in general practice. London: The King’s Fund (https://www.kingsfund.org.uk/publications/effective-teams-general-practice). These web-based guidelines are targeted at primary care team managers and practitioners, with practical advice on building effective teams. They touch on processes for setting objectives, recruiting the right team members, establishing and maintaining fluid communication, setting up a physical space conducive to teamwork, ensuring effective management and self-management, and engaging with patients.


Collins B (2015). Intentional whole health system redesign. Southcentral Foundation’s “Nuka” system of care. London: King’s Fund (https://www.kingsfund.org.uk/sites/default/files/field_publication_file/intentional-whole-health-system-redesign-Kings-Fund-November-2015.pdf). The report describes the redesign of the health system serving Alaska native people in Anchorage, Alaska, starting in the 1990s. It is widely regarded as one of the most successful examples of health-system redesign and provides an example of orderly and intentional whole-health-system redesign, starting with careful consultation with the community, followed by the development of objectives and principles that inform the service-delivery model and allocation of resources.

Groundwork [website] (2021). Windischgarsten, Austria; Art of Hosting (http://thegroundwork.weebly.com/). This is the website for Groundwork Practice, part of The Art of Hosting, an approach for organizing and collaborating in complexity that is based on the nature of living systems. It includes the Groundwork Framework and information on online and in-person training.

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2 All URLs accessed on 29 March 2021.

This is a case study on the integration of public health and primary care in Slovenia. In addition to sharing Slovenia’s positive experience, the report also analyses the root causes of the health-system performance problems Slovenia still faces. The report’s emphasis on health-system issues should make it of interest to policy-makers and others interested in improving their primary health-care system.


A scoping review identifying the shared functions of public health and primary health care, as well as organizational models that could facilitate the interaction between the two domains. The whole text is available through open access.


This blog post on the United Kingdom NAPC website discusses why primary care networks should incorporate community engagement into their planning processes and highlights how some networks are taking this forward.


This online repository of resources enables local systems to implement and embed community-centred approaches to health and well-being at scale.


An online article explaining the principles, framework and pathways to increase community engagement in primary care, it includes additional links to resources, examples and planning tools.


A brief editorial presenting arguments and avenues for achieving a health model for primary care that integrates key public health concepts. High-quality primary health-care services are considered to be the backbone of a strong health system.


This policy brief explores how primary care and public health can be brought together to improve the health of patients and populations. It describes the types of initiatives that have been undertaken, provides examples of such initiatives in Europe and beyond, and summarizes the factors that can help to enhance or hinder the integration of primary care and public health.

This report reflects the views of 16 chairs and leads of both sustainability and transformation partnerships (which are being phased out) and integrated care systems (which are being phased in) on the challenges involved in making this transition.


The WHO website for community engagement in health services, it includes links to resources, tools and frameworks for increasing community engagement across a range of health-service sectors.


This report synthesizes literature to illustrate how a participative approach to leadership could offer a better strategy for improving health systems.


This report draws from successful experiences of collaboration between public health and primary health care in five European countries (Austria, Denmark, Italy, the Netherlands and Sweden), discussing the preconditions that must be met for collaboration to take place and making recommendations on how to apply these lessons in countries.


The framework is aimed at policy-makers, human resources for health planners and professionals with a particular interest in the public health workforce, and other stakeholders such as education institutions, public health institutes and others responsible for implementing policy and professional organizations. It is designed to support the application to the public health workforce of the tools presented in The toolkit for a sustainable health workforce in the WHO European Region, including measures to strengthen education and performance, planning and investment, capacity-building, analysis and monitoring.


Three reports from a WHO technical series on PHC.

• The background report provides evidence and a rationale supporting the Declaration of Astana, with its continued political focus on the right to integrated, quality, personal and population-level primary care, health as a multisectoral social and economic construct that is dependent on many sectors; and community engagement in health and empowerment with respect to health services.

• The report on integration discusses strategies and operational changes needed to integrate public health actions into primary care.

• The operational framework is a draft open for consultation with Member States. (as per the timing of the retreat).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

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