Operational Framework

Primary health care: transforming vision into action

Interim Draft

for consideration at the 146th Session of the Executive Board of the

World Health Organization

Contents

Preface

This document is the result of collaborative work led by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). An initial draft was prepared as part of a technical series of documents to support the Global Conference on Primary Health Care, held in Astana, Kazakhstan, in October 2018.

This Operational Framework, the related *Vision for Primary Health Care in the 21st Century*, and the associated technical documents are informed by reviews of the literature, 2018 regional reports on primary health care, country case studies on primary health care, a synthesis of lessons learned over the last 40 years, a number of workshops with key stakeholders that agreed on a global roadmap, input from the International Advisory Group on Primary Health Care, public consultations, expert review, and thematic reports on key issues relevant to primary health care.

This document series builds on WHO's work on primary health care over the past 40 years, notably the Global Strategy for Health for All by the Year 2000, Primary Health Care 21: "Everybody's business", the Commission on Social Determinants of Health, the WHO Framework for Action for Strengthening Health Systems to Improve Health Outcomes, the *World health report 2008*, and the WHO Framework on Integrated People-centred Health Services.

Since its initial release at the Global Conference on Primary Health Care, the revision of this document has been informed by a public consultation, a civil society consultation, key informant interviews and a Member State consultation. The current document is a working draft to be presented at the 146th session of the WHO Executive Board.

Acknowledgements

The initial draft of this document was produced as part of a technical series on primary health care on the occasion of the Global Conference on Primary Health Care under the overall direction of Naoko Yamamoto (Assistant Director for Health Systems and Universal Health Coverage, WHO), Zsuzsanna Jakab (Director of the WHO Regional Office for Europe) and Ted Chaiban (Director of Programmes, UNICEF). The work was in response to a letter from the Minister of Health of Kazakhstan, Dr Yelzhan Birtanov, proposing to capitalize on the 40th anniversary of the landmark International Conference on Primary Health Care in Alma-Ata by updating its Declaration on Primary Health Care. The coordination team for the Global Conference was led by Ed Kelley (WHO), Hans Kluge (WHO Regional Office for Europe) and Vidhya Ganesh (UNICEF).

Overall technical coordination was provided by Shannon Barkley (WHO), David Hipgrave (UNICEF), and Pavlos Theodorakis (WHO Regional Office for Europe). The principal writing team consisted of Toby Kasper (independent consultant), Katherine Rouleau (University of Toronto, Canada), Sameen Siddiqi (Aga Khan University, Pakistan) and Jose M. Valderas (University of Exeter, United Kingdom).

Valuable comments and suggestions were made by technical experts, additional collaborating partners and regional and country office staff of WHO, UNICEF and the World Bank, in particular: Samson Agbo, Ainur Aiypkhanova, Luke Allen, Anshu Banerjee, Ernesto Bascolo, Anjana Bhushan, Khalif Bile, Melissa Bingham, Luisa Brumana, Ketan Chitnis, Mickey Chopra, Ogochukwu Chukwujekwu, David Clarke, Amalia del Riego, Rene Ehounou Ekpini, Tarcisse Elongo, Magdy El Sanadi, Emad Ezat, Ricardo Fabrega, Gabriele Fontana, Sandra Fraifer, Abdul Ghaffar, Ariana Grande, Richard Gregory, Ann-Lise Guisset, Anouk Hamers, Matthew Jowett, Rania Kawar, Ghazanfar Khan, Karen Kinder, Hernan Luque, Etienne Langlois, Lizzie Madden, Lina Mahy, Jeff Markuns, Inke Mathauer, Lúcio Meneses de Almeida, Fatoumata Nafo-Traoré, Khin Pa Pa Naing, Matthew Neilson, Ngashi Ngongo, Hideaki Nishizawa, Asiya Odugleh-Kolev, Anthony Ofosu, Yuri Oksamitniy, Yu Lee Park, Walaiporn Patcharanarumol, Jerome Pfaffman, Geetha Gopalakrishna Pillai, Dheepa Rajan, Briana Rivas-Morello, Paul Rutter, Hassan Salah, Gerard Schmets, Diana Sera, Manisha Shridhar, Shams Syed, Mohammed Rasoul Tarawneh, Juan Tello, Nuria Toro Polanco, Prosper Tumusiime, Nicole Valentine, Adriana Velazquez Berumen, Wendy Venter, Karen Vincenti, Francesco Zambon and Diana Zandi.

Subsequently, the draft document was opened for public comment and feedback was received from more than 70 organizations and individuals. Additional consultations were held with civil society organizations, technical experts and Member States.

Abbreviations

AIDS	acquired immune deficiency syndrome
AMR	antimicrobial resistance
DHIS2	District Health Information System 2
HIV	human immunodeficiency virus
ICT	information and communication technology
JLN	Joint Learning Network for Universal Health Coverage
OECD	Organisation for Economic Co-operation and Development
P4P	pay for performance
PHC	primary health care
PHCPI	Primary Health Care Performance Initiative
SDG	Sustainable Development Goal
UHC	universal health coverage
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization

Glossary

Access (to health services). The ability, or perceived ability, to reach health services or health facilities in terms of location, timeliness and ease of approach.

Accountability. The obligation to report or give account of one's actions, for example, to a governing authority through scrutiny, contract, management and regulation or to an electorate.

Ambulatory care sensitive conditions. Chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active primary care, for example, asthma, diabetes and hypertension.

Amenable morbidity. The incidence of illness considered avoidable by healthcare interventions.

Amenable mortality. Deaths considered avoidable by healthcare interventions.

Care coordination. A proactive approach that brings care professionals and providers together around the needs of service users to ensure that people receive integrated and person-focused care across various settings.

Case management. A targeted, community-based and proactive approach to care that involves case-finding, assessment, care planning and care coordination to integrate services around the needs of people with a high level of risk requiring complex care (often from multiple providers or locations), people who are vulnerable, or people who have complex social and health needs. The case manager coordinates patient care throughout the entire continuum of care.

Change management. An approach to transitioning individuals, teams, organizations and systems to a desired future state.

Coherence (of a national health policy, strategy or plan). (a) The extent to which proposed strategies are aligned with the priorities identified in the situation analysis; (b) the extent to which programme plans are aligned with the national health strategy and plan; (c) the extent to which the different programmatic strategies in the national health policy, strategy or plan are coherent with each other; or (d) the extent to which the budget, monitoring and evaluation framework and action plan introduce the proposed strategies.

Collaborative care. Care that brings together professionals or organizations to work in partnership with people to achieve a common purpose.

Community. A unit of population, defined by a shared characteristic (geography, interest, belief, social characteristic), that is the locus of basic political and social responsibility and in which everyday social interactions involving all or most of the spectrum of life activities of the people within it takes place.

Community health worker. Person who provides health and medical care to members of their local community, often in partnership with health professionals; alternatively known as village health worker, community health aide or promoter, health educator, lay health adviser, expert patient, community volunteer or some other term.

Comprehensiveness of care. The extent to which the spectrum of care and range of available resources responds to the full range of health needs of a given community. Comprehensive care encompasses health promotion and prevention interventions, as well as diagnosis and treatment or

referral and palliation. It includes chronic or long-term home care and, in some models, social services.

Continuity of care. The degree to which a series of discrete healthcare events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences.

Co-production of health care. Health services that are delivered in an equal and reciprocal relationship between professionals, people using care services, their families and the communities to which they belong. Co-production implies a long-term relationship between people, providers and health systems whereby information, decision-making and service delivery become shared.

Chronic care. Health care that addresses the needs of people with long-term health conditions.

Disease management. A system of coordinated, proactive healthcare interventions of proven benefit and communications to populations and individuals with established health conditions, including methods to improve people's self-care efforts.

Effectiveness. The extent to which a specific intervention, procedure, regimen or service does what it is intended to do for a specified population when deployed in everyday circumstances.

eHealth. Information and communication technologies that support the remote management of people and communities with a range of healthcare needs through supporting self-care and enabling electronic communications among health workers and between health workers and patients.

Empowerment. The process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or an increase in the ability to self-manage illnesses.

Engagement. The process of involving people and communities in the design, planning and delivery of health services, thereby enabling them to make choices about care and treatment options or to participate in strategic decision-making on how health resources should be spent.

Equity in health. The absence of systematic or potentially remediable differences in health status, access to health care and health-enhancing environments, and treatment in one or more aspects of health across populations or population groups defined socially, economically, demographically or geographically within and across countries.

Essential public health functions. The spectrum of competencies and actions that are required to reach the central objective of public health — improving the health of populations. This document is focused on the core or vertical functions: protection, promotion, prevention, surveillance and response, and emergency preparedness.

First level of care. The entry point into the healthcare system at the interface between services and community; when the first level of care satisfies a number of quality criteria, it is called primary care. *See*: primary care.

Fragmentation (of health services). (a) Coexistence of units, facilities or programmes that are not integrated into the health network; (b) services that do not cover the entire range of promotion, prevention, diagnosis, treatment, rehabilitation and palliative care services; (c) services in different platforms of care that are not coordinated among themselves; or (d) services that do not continue over time.

Goal-oriented care. Care that is planned and delivered based on goals and targets as explicitly elicited from each individual for the achievement of the highest possible level of health, as defined by that individual.

Health. State of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Holistic care. Care that considers the whole person, including psychological, social and environmental factors, rather than just the symptoms of disease or ill health.

Horizontal integration. Coordination of the functions, activities or operating units that are at the same stage of the service production process; examples of this type of integration are consolidations, mergers and shared services within a single level of care.

Indicator. Explicitly defined and measurable metric that helps in the assessment of the structure, process or outcomes of an action or a set of actions.

Integrated health services. The management and delivery of health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services through the different functions, activities and sites of care within the health system.

Integrated health services delivery network. A network of organizations that provides or makes arrangements to provide, equitable, comprehensive and integrated health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and for the health status of the population that it serves.

Course of life approach. An approach suggesting that the health outcomes of individuals and the community depend on the interaction of multiple protective and risk factors throughout people's lives. This approach provides a more comprehensive vision of health and its determinants, which calls for the development of health services more centred on the needs of its users at each stage of their lives.

Mental health. A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community.

Multisectoral action on health. Policy design, policy implementation and other actions related to health and other sectors (for example, social protection, housing, education, agriculture, finance and industry) carried out collaboratively or alone, which address social, economic and environmental determinants of health and associated commercial factors or improve health and well-being.

Mutual (shared) accountability. The process by which two (or multiple) partners agree to be held responsible for the commitments that they have made to each other.

People-centred care. An approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in and beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care.

Personal health services. Health services targeted at the individual, including health promotion, timely disease prevention, diagnosis and treatment, rehabilitation, palliative care, acute care and long-term care services.

Population health. An approach to health care that seeks to improve the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Primary care. A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.

Primary health care. A 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.

Primary health care-oriented health system. Health system organized and operated so as to guarantee the right to the highest attainable level of health as the main goal, while maximizing equity and solidarity. A primary health care-oriented health system is composed of a core set of structural and functional elements that support achieving universal coverage and access to services that are acceptable to the population and equity enhancing.

Quality care. Care that is safe, effective, people-centred, timely, efficient, equitable and integrated.

Regulation. The imposition of constraints upon the behaviour of an individual or an organization to force a change from preferred or spontaneous behaviour.

Resilience. The ability of a system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions.

Self-care. Individuals, families and communities are supported and empowered to appropriately manage their health and well-being when not in direct contact with health services.

Stakeholder. An individual, group or organization that has an interest in one or multiple aspects of the health system.

Stewardship. A responsibility for the effective planning and management of health resources to safeguard equity, population health and well-being.

Universal health coverage. Ensuring that all people have access to needed promotive, preventive, curative, rehabilitative, and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship.

Vertical integration. The coordination of the functions, activities or operational units that are in different phases of the service production process. This type of integration includes the links between platforms of health service delivery, for example between primary and referral care, hospitals and medical groups or outpatient surgery centres and home-based care agencies.

Vertical programmes. Health programmes focused on people and populations with specific (single) health conditions.

Well-being. A multidimensional construct aiming at capturing a positive life experience, frequently equated to quality of life and life satisfaction. Measures of well-being typically focus on patient-reported outcomes covering a wide range of domains, such as happiness, positive emotions, engagement, meaning, purpose, vitality and calmness.

Note: Definitions in this glossary are adapted from the following sources:

Health systems strengthening glossary. Geneva: World Health Organization (http://www.who.int/healthsystems/hss_glossary/en/).

WHO global strategy on people-centred and integrated health services: interim report. Geneva: World Health Organization; 2015 (http://www.who.int/iris/handle/10665/155002).

Essential public health functions, health systems and health security: developing conceptual clarity and a WHO roadmap for action. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272597/9789241514088-eng.pdf).

Wellbeing measures in primary health care: the Depcare project. Copenhagen: WHO Regional Office for Europe; 1998 (http://www.euro.who.int/__data/assets/pdf_file/0016/130750/E60246.pdf).

1. Introduction

The Declaration of Astana on Primary Health Care and the accompanying *Vision for Primary Health Care in the 21st Century* reinforce the commitment of countries and international partners to make concerted efforts to orient health systems towards primary health care (PHC) for accelerated progress on universal health coverage and the health-related Sustainable Development Goals (SDGs). The *Vision for Primary Health Care in the 21st Century* emphasizes a comprehensive PHC approach by proposing three components of PHC:

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

1.1 Primary health care levers and the Operational Framework

The global commitments in the Astana Declaration – to make bold political choices for health across all sectors, build sustainable primary health care, empower individuals and communities, and align stakeholder support to national policies, strategies and plans – must be transformed into visible actions to bring about demonstrable change. The *Vision for Primary Health Care in the 21st Century* described the three components of PHC, that is, "what" needs to be delivered, and also proposed a set of levers to help countries to advance across the components of PHC. Expanding on the health system building blocks, these levers address key elements of the health system that can be used to accelerate progress on PHC. Of note, they do not repeat the technical or programme aspects of PHC in the *Vision for Primary Health Care in the 21st Century*. Hence, this document does not address the issue of what types of services should be included as part of primary care (for example, there is no discussion of specific strategies addressing undifferentiated conditions, reproductive, maternal, newborn, child and adolescent health and nutrition, human immunodeficiency virus/acquired immune deficiency syndrome [HIV/AIDS], mental health or other non-communicable diseases).

A Vision for Primary Health Care in the 21st Century contains only brief descriptions of each lever. In this Operational Framework, more in-depth information is provided on each lever to guide countries' implementation efforts in strengthening PHC-oriented health systems towards health for all, without distinction of any kind[1]. Although all levers are interdependent and interrelated, the levers are separated into ones that primarily function at the core strategic and operational levels. Core strategic levers can pave the way for actions around other levers, but any sustainable improvement around the operational levers is unlikely without a strong grounding in the strategic levers. Actions and interventions around each lever are thus not intended to be carried out

[1] Note: Following consultation on the draft Operational Framework, the structure and representation of certain levers have been revised and may not represent the levers verbatim as they appear in the *Vision for Primary Health Care in the 21st Century*, although the overall content remains the same.

independently, but should be mutually and comprehensively considered throughout inclusive national health planning processes. Table 1 summarizes the levers.

TABLE 1: OVERVIEW OF PRIMARY HEALTH CARE LEVERS

Title	Full description
Core strategic levers	
Political commitment and leadership	Political commitment and leadership that place PHC at the heart of efforts to achieve universal health coverage and recognize the broad contribution of PHC to the SDGs
Governance and policy frameworks	Governance structures, policy frameworks and regulations in support of PHC that build partnerships within and across sectors, and promote community leadership and mutual accountability
Funding and allocation of resources	Adequate financing for PHC that is mobilized and allocated to minimize financial hardship, promote equity and enable high-quality care and services
Engagement of community and other stakeholders	Engagement of communities and other stakeholders from all sectors to define problems and solutions and prioritize actions through policy dialogue
Operational levers	
Models of care	Models of care that promote high-quality, people-centred primary care and essential public health functions as the core of integrated health services throughout the course of life
Primary health care workforce	Adequate quantity, competency levels and distribution of a committed multidisciplinary primary healthcare workforce that includes facility-, outreach-, and community-based health workers supported through effective management supervision and appropriate compensation
Physical infrastructure	Secure and accessible primary care facilities to provide effective services with reliable water, sanitation and waste disposal/recycling, telecommunications connectivity and a power supply, including transport systems that can connect patients to other care providers
Medicines and other health products	Availability and affordability of appropriate, safe, effective, quality medicines and other health products through transparent processes to improve health
Engagement with private sector providers	Sound partnership between public and private sectors for the delivery of integrated health services
Purchasing and payment systems	Purchasing and payment systems that foster a reorientation in models of care towards prevention and promotion and towards care delivered closer to where people live and work. Such systems provide incentives for the delivery of high-quality primary care services and facilitate integration and coordination across the continuum of care
Digital technologies for health	Use of digital technologies for health in ways that facilitate access to care and service delivery, improve effectiveness and efficiency, and promote accountability
Systems for improving the quality of care	Systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health services
Primary health care-oriented research	Research and knowledge management, including dissemination of lessons learned, as well as the use of knowledge to accelerate the scale-up of successful strategies to strengthen PHC-oriented systems
Monitoring and evaluation	Monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors

For each lever, a consistent structure is used:

- narrative description
- actions and interventions that can be applied at policy, operational and implementation levels
- case studies demonstrating the implementation of lever(s) and related outcomes are currently under development and will be provided in an Annex to this document prior to the World Health Assembly.

Each of these sections draws extensively on the published literature, existing guidance documents, and, in some areas, agreements that have already been made between the World Health Organization (WHO) Member States in the context of the World Health Assembly.

The document concludes with a section on how international partners can better support countries to operationalize the Astana Declaration.

1.2 Who should use this document

The document is primarily intended to assist countries in their efforts to improve PHC and governments, both national and subnational, are a key audience, particularly since many WHO Member States have committed themselves to improving PHC. In addition, many of the actions are relevant for other stakeholders at the country level, such as nongovernmental organizations, the private sector, and development partners. Those in academia may find this document useful for identifying areas requiring further research. Given the central role of people and communities in PHC, each table of actions has a dedicated column focused on these roles.

The document also highlights the role of international partners in supporting the efforts of countries to improve PHC. This can be facilitated by the Global Action Plan for Healthy Lives and Well-being for All, an initiative through which international partners are looking afresh at how they can collaborate more effectively in order to accelerate PHC progress.

1.3 How this document should be used

The Operational Framework levers should be used to guide and inform national planning processes and decision-making for the implementation of PHC. A number of actions is proposed for each lever. However, the levers and their related actions are not intended to provide a one-size-fits-all approach. The levers and actions will have a different significance among countries at different levels of social and economic development, as well as different degrees of PHC orientation and health status. This document is intended to be applicable to a wide range of countries and thus includes a range of actions, not all of which will be appropriate or priorities in every country and, in any case, they cannot all be completed simultaneously. The tables of actions provide a menu of practical, evidence-based suggestions that countries can contextualise to accelerate efforts around PHC. Countries will need to assess, prioritize, optimize and sequence the levers and actions within them, while considering specifically how the core strategic levers might be leveraged to facilitate the operational levers.

The selection and implementation of specific actions should be informed by evidence, both local (for example, the social, economic, and environmental situation and trends in the country, the disease burden, and the strengths and weaknesses of the health system) and global (for example, what has been shown to work in improving PHC and what does not work), as well as by the values and preferences of a diverse range of stakeholders. In addition, actions should be refined according to progress and as further evidence and experience are generated to advance PHC. This should typically

be done in the context of an inclusive planning process built on a robust evidence base to identify local, subnational and national priorities for health, with community participation that includes those most vulnerable and disadvantaged.

Recognizing that appropriate implementation around the levers requires high quality data to inform policy decisions, a framework for monitoring and evaluation of PHC will be prepared as a supplementary tool. It will include indicators aligned to the 14 levers, which can be used by countries and other stakeholders to track relevant input, processes, outputs, and outcomes for each lever, and overall PHC progress as part of health sector reviews. Priority indicators should be selected based on national or subnational needs and context, as well as feasibility of measurement and actionability.

1.4 Way forward

Incremental health system change will not be sufficient and the pace of progress towards PHC and universal health coverage must be accelerated to leave no one behind. The Astana Declaration sets out a bold vision for PHC, but it is up to countries themselves — with the support of the international community — to translate these words into meaningful change. Therefore, the extent to which countries embrace the actions set out in the declaration will determine whether or not progress is made on improving PHC. For many countries, this will require substantial transformation of the ways in which health-related policies and actions are prioritized, developed, funded and implemented. Such reorientation towards PHC relies on a bold vision backed by the four core strategic levers – political commitment and leadership, governance and policy frameworks, funding and allocation of resources, and the engagement of community and other stakeholders – at all levels and across all sectors. Harmonization and alignment of global donors and partners under the leadership and governance of countries will be especially critical to ensure integrated support to national plans and priorities for PHC implementation.

2. Core strategic levers

2.1 Political commitment and leadership

Political commitment and leadership that place PHC at the heart of efforts to achieve universal health coverage and recognize the broad contribution of PHC to the SDGs

The history of global health is in many ways a history of political commitment and leadership: areas that have seen sustained commitment and leadership have witnessed impressive changes, while those that have not, have often languished. Commitment and leadership within the health sector is important, but truly transformational change requires commitment and leadership beyond the health sector: the involvement of heads of state/government, other political leaders (for example, parliamentarians) and influential community, religious and business figures is important for mobilizing large-scale improvements in PHC.

These leaders must ensure that PHC is treated as a priority by formalizing commitments to it (for example, through declarations, by highlighting it in key documents, such as national development plans and/or plans to achieve the SDGs), by regularly communicating about its importance, by providing adequate financing and, ultimately, by focusing on the implementation of efforts to improve PHC. This commitment and leadership is particularly important because of the ambitious vision of PHC, in particular, the complexities associated with the three components of PHC: integrated health services, multisectoral policy and action, and empowered people and communities. Effectively delivering integrated health services requires political commitment and leadership as health systems are too often skewed away from public health and primary care. In particular, tertiary care is often privileged at the expense of primary care, and public health functions frequently suffer from underinvestment. Embracing the vision of PHC means taking difficult decisions to reprioritize resources and reorient systems.

Addressing social, economic, environmental and commercial determinants of health through multisectoral policy and action cannot be done without political commitment and leadership because of the considerable challenges associated with multisectoral responses. In particular, multisectoral policy and action requires tackling the silo approach that leads to the separation of sectors, as well as the different incentive regimes that different sectors may operate under (for example, non-health ministries will have their own priorities that may or may not result in a focus on the areas that are most important for improving health outcomes). In many countries, ministries of health do not have sufficient power and influence to tackle this challenge on their own and need support from the top levels of government. Additionally, the status quo — including social, economic, environmental and commercial factors that harm health — is often supported by entrenched and powerful interests that are not keen to accommodate change. Overcoming this resistance requires concerted political commitment and leadership. Finally, multisectoral policy and action often requires the development of partnerships that cut across sectors and involve public and private actors. There is strong evidence that these require commitment and leadership to thrive.

Similarly, empowering people and communities entails making difficult decisions that require commitment and leadership. Many of the populations that have the worst health statuses face systemic disadvantages, such as race, ethnicity, gender, sexual orientation, socioeconomic status, location (for example, rural), religion, educational status and disability. In this context, empowerment requires a redistribution of power to fully engage all people and communities, which again cannot be achieved without strong political commitment and leadership. Within these communities — even marginalized ones — there are also opportunities for individuals to demonstrate leadership and support the empowerment of others.

The history of efforts to implement PHC highlights an important pitfall to avoid. Although a comprehensive approach to PHC should be positioned as a foundation of efforts to achieve universal health coverage, this has not always happened as it is often easier to favour selective approaches that have ready-made constituencies over the broader-based approach of PHC. Therefore, achieving the vision of PHC requires stronger political commitment and leadership than that which characterized the past 40 years since Alma-Ata.

TABLE 2: POLITICAL COMMITMENT AND LEADERSHIP: ACTIONS AND INTERVENTIONS

At national level
• Cultivate champions for PHC from across influential sectors of society (government, community, religious, business), either through formal structures (for example, high-level groups) or individually (for example, ambassadors). • Develop a comprehensive vision of PHC and formalize commitment to PHC as a priority government-wide (for example, through formal declarations, policies or laws; by integrating it as a core component of national strategies, including both broader development strategies, such as national development plans and plans to achieve the SDGs; and health sector-specific strategies) and by ensuring that there are adequate cross-governmental structures in place to oversee PHC. • Communicate extensively about the commitment to improve PHC. • Ensure that the rhetoric on commitment is matched by the provision of adequate financing for PHC (see also Section 2.3). • Hold accountable those responsible for the implementation of PHC (including not only ministries of health, but also other government leaders, such as parliamentarians, and ministries required to address other determinants of health). • Create an enabling environment for participation by proactively identifying barriers and opportunities for empowering people and communities, by building community capacities for meaningful dialogue, and by providing and regularly evaluating policy dialogue mechanisms. • Follow through on commitments to adopt human rights-based approaches.
At sub-national level
• Collaborate with higher administrative levels to ensure that community needs and views are given appropriate attention in decision-making. • If appropriate given the level of decentralization, carry out the same efforts at the subnational level as at the national level: ○ cultivate local champions ○ formalize commitments to PHC (including by integrating PHC as a core component of local development and health strategies) ○ communicate about the commitment to PHC ○ provide adequate financing.
By people and communities
• Hold political leaders accountable for improving PHC • Develop networks at community level to ensure that community voices are heard • Participate in efforts to establish inclusive processes • Demonstrate leadership as a champion for the comprehensive vision of PHC • Share information about good practices around accountability among peers (both within and between countries).

2.2 Governance and policy frameworks

Governance structures, policy frameworks and regulations in support of PHC that build partnerships within and across sectors, and promote community leadership and mutual accountability

Governance refers to "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability" *(1)*. Historically, in most low- and middle-income countries, governments have focused on delivering public sector services themselves, rather than embracing a broader vision of governance. This arrangement is becoming increasingly outmoded, given both the range of actors increasingly involved in PHC and the recognition that PHC encompasses areas in which the ministry of health cannot act as a service provider. For example, the private sector (either for-profit or not-for-profit) is a crucial player in health in many settings and the importance of involving actors from other sectors is increasingly recognized.

This broader vision of governance requires that governments oversee and guide the health system as a whole, not just the public system, to protect the public interest *(1, 2)*. The transformation from the traditional role of ministries of health as providers of services to stewards for health that engage a full range of actors (including from other sectors) has not been an easy one in many low- and middle-income countries, but this transformative change in the governance of health is critical for a comprehensive approach to PHC.

In many countries, embracing the role of steward will require changes and capacity building for ministries of health. The shift from focusing primarily on providing services directly to guiding a health system that mixes public and private provision requires the development of skills in partnership, monitoring, oversight and regulation.

Another important dimension in improving governance is increasing the role of communities. This can make PHC systems more responsive, not only because it allows rapid recognition of local concerns, but also because communities can more effectively advocate to have their emerging needs recognized. This can lead to a prompt response, in contrast to distant sub-national and national governments, which may not be able to react with a similar agility or flexibility. Leveraging this role needs effective governance structures and processes that allow for better community participation, enhanced legitimacy and improved accountability, resulting in sustainable, equitable and quality health care. Examples of such a governance structure include having community-elected representatives participate as full members of facility or district management structures or establishing a community advisory board that has a formal role in providing an oversight of health services.

In the absence of formal roles of communities in local health governance, healthcare providers and managers may remain resistant to community accountability and respond only to internal government or organizational accountability mechanisms. Legitimizing the roles of community networks can ensure that district health systems effectively allow participation, fulfil user needs, and are accountable to the individuals and communities they serve. Such local health governance has to be embedded in supportive national and sub-national health systems to ensure transparency and equity so that local power structures and existing inequities are not reflected in decentralized health systems. Such multilevel governance also makes health systems more resilient, as one level can compensate for governance gaps at another level.

Another important shift that should be embraced is a "whole-of-government" approach, particularly given the need for multisectoral policy and action. An important tool for doing this is the Health in

All Policies approach, which was officially defined by the World Health Assembly in 2014 as “an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity” *(3, 4)*. In the Health in All Policies approach, the health sector is seen as the champion for health, keeping health firmly on the political agenda, but aware of the need for joined-up work that seeks overall societal gains *(5)*.

There is no single model for implementing Health in All Policies, but experience from across the world has led to the identification of a set of characteristics that are key to successful implementation: “good governance; development of strong and sound partnerships based on co-design, co-delivery, and co-benefits; dedicated capacity and resources; and the use of evidence and evaluation” *(6)*. WHO has developed a series of materials that can help countries to initiate, implement and sustain Health in All Policies, including a training manual and a series of case studies *(7–9)*.

Monitoring and evaluation are covered separately (see Section 3.11), but it is important to highlight the critical role that transparency and access to data have in ensuring good governance. These are required for governments to fulfil their stewardship roles, for civil society to be able to press for accountability, and for multisectoral actors to understand the linkages between their work and health outcomes. The media and individuals have an important role to play in ensuring that accurate health information is publicized and made widely available, as social media and other technology-driven shifts increasingly enable user-generated content to spread widely.

These shifts in governance should be supported by policy frameworks that reflect the broad definition of PHC. In particular, the concept of PHC as having three interrelated components, that is, integrated health services, multisectoral policy and action, and empowered people and communities, should be embedded in key policy frameworks that govern the health sector. As PHC is an orientation and not simply a programme, it does not necessarily mean that each country should have a dedicated PHC policy. Instead, it is more important that the comprehensive vision of PHC is included in the set of policy frameworks that are most relevant for each country. This could include a national health policy/strategy, a strategy for universal health coverage, sub-sector policies, or for areas such as the health workforce or medicines, and even programme strategies addressing issues such as reproductive, maternal, newborn, child, and adolescent health and nutrition, or HIV/AIDS.

The process of developing and then implementing these frameworks should also embrace a PHC orientation. This includes using a participatory approach that empowers people and communities to play an active role in shaping the policies that influence their lives. This requires moving beyond solely technocratic processes that rely only on experts in capital cities to using methodologies that engage people and communities where they are, including an acknowledgement of the complexity of the power dynamics that shape the ability of people and communities to participate meaningfully.

TABLE 3: GOVERNANCE AND POLICY FRAMEWORKS: ACTIONS AND INTERVENTIONS

At national level
• Develop the ministry of health's stewardship role and technical capacities to facilitate multisectoral arrangements with other ministries and institutions and to enable partnerships with the private sector and other actors (such as professional associations and trade unions) when and where useful and appropriate. • Legitimize the role of communities in local health governance by the creation of institutional mechanisms and processes that allow for greater community and civil society involvement in a non-discriminatory manner (for example, community-elected representatives in governance structures, community advisory boards). • Provide funding and oversight to collaborative community governance of PHC to ensure the availability of adequate resources and their equitable use. • Establish legislative mandates and a clear governance and accountability framework for a Health in All Policies approach and dedicate resources to support and sustain multisectoral work. • Ensure accountability for PHC in the ministry of health in a manner that works across the traditional departmental boundaries and is linked to the team(s) responsible for universal health coverage and SDGs. • Use evidence to document the linkages between health and other government policy priorities (including by using methodologies more commonly used in other sectors, such as economic modelling and qualitative research). • Support the use of audit tools, such as health impact assessments and policy audits, to enable transparency in the examination of health and equity outcomes of policies. • Support efforts to making the data public about the performance of health services, even if the findings are not positive. • Reflect a PHC orientation across all relevant policy and strategy frameworks.
At sub-national level
• Reform and align the integrated PHC-oriented governance mechanism and planning processes at the sub-national level to respond to its three components • Create community-based multi-stakeholder forums for collective accountability and action on health and health-related issues. • Create an organizational culture that supports monitoring and evaluation through knowledge sharing, open feedback and a demand for data in decision-making processes. • Strengthen PHC management protocols that encourage provider report cards, patient satisfaction surveys, patient-reported outcomes and balanced scorecards. • Support public, private and community actors to develop competencies for engaging across the PHC components.
By people and communities
• Advocate for community-steered institutional arrangements to which government officials responsible for PHC are accountable. • Participate in efforts to establish inclusive processes (for example, by engaging in planning forums). • Disseminate widely data on health service performance.

2.3 Funding and allocation of resources

Adequate financing for PHC that is mobilized and allocated to minimize financial hardship, promote equity, and enable high-quality care and services

For PHC to be delivered successfully, there is a need to raise sufficient and sustainable resources, manage them equitably and efficiently by pooling them, and use the pooled funds for needed programmes, services and interventions.

Resources generally come from one of three sources: domestic public revenue, private sources (particularly, voluntary pre-paid contributions and out-of-pocket expenditure), and external development assistance for health. The balance between these sources tends to vary significantly according to a country's income level: low- and lower-middle-income countries often rely heavily on out-of-pocket payments (which is a significant contributor to worsening inequality), whereas in upper-middle- and high-income countries, domestic public financing generally predominates. External financing is a small share in most countries, except for a limited number of primarily low-income ones.

Given that out-of-pocket expenditure tends to increase inequality and development assistance for health has largely plateaued in recent years, many countries are focusing on domestic public resources as the key source for financing increases in health expenditure. The share of domestic resources spent on PHC is largely a function of three factors:

1. the share of a country's gross domestic product that goes to general government expenditure
2. the share of general government expenditure that goes to health
3. the share of health expenditure that goes to PHC.

There is significant variability across countries on all three of these dimensions and it has historically been quite difficult to quantify expenditure on PHC. The methodology for accounting for health expenditure (the System of Health Accounts 2011) does not include a direct measure of expenditure on PHC, but WHO published the first preliminary data estimating PHC expenditure for the Astana Conference (*10*). Work is still underway on refining this as it does not include expenditure that reflect the multisectoral nature of PHC.

The overall picture is of insufficient financing for PHC. Of the 13 low-income countries for which data are available, none spent more than US$ 50 per capita on PHC in 2016, and only three spent more than US$ 30 per capita on PHC (*11*).

The most effective approach to increasing domestic financing for PHC will vary considerably depending on both a country's starting point (for example, the solution in a country that raises very little revenue as a share of its gross domestic product is likely to be different from one that mobilizes sufficient revenue overall, but allocates only a small share to health) and local political economic considerations. In general, efforts to raise resources for PHC should be embedded in a broader health financing strategy that encompasses the entire health sector. Developing or updating a health financing strategy should be undertaken in collaboration with a range of stakeholders, both within the health sector and outside it (for example, ministries of finance).

Such a strategy should also address key issues related to the allocation of resources within the health sector. In particular, a key challenge in many countries is that tertiary facilities receive disproportionately large shares of health budgets. This both reduces the financing available for PHC

and increases costs to the entire health system, with an over-reliance on using hospitals to deliver primary care services being a significant driver of inefficiency in many countries.

While developing or reviewing health financing strategies, countries need to ensure that PHC programmes are appropriately funded, vulnerable population groups are adequately protected, and resources are efficiently used during implementation to reduce the rising inequities in the financing of health care. Further, within the PHC components, funds should be rationally allocated among primary care and public health programmes and initiatives that promote community engagement and multisectoral coordination.

Addressing the issue of allocation to PHC is a critical aspect of improving financing, but it is not the only dimension. In particular, inefficient spending on PHC creates two problems: not only are scarce resources wasted, but officials who manage government budgets (for example, in ministries of finance) may be reluctant to allocate additional resources to PHC until evidence is provided that current resources are being used efficiently. In many countries, public financial management systems require strengthening in order to be able to track expenditure robustly and generate data that can be used to address sources of inefficiency.

The question of how to use resources that have been mobilized to pay for health services is covered separately in Section 3.9.

TABLE 4: FUNDING AND ALLOCATION OF RESOURCES: ACTIONS AND INTERVENTIONS

At national level
• Develop health financing strategies that explicitly mention allocations for and spending on PHC, based on data about current patterns of revenue mobilization (including areas in which a country is significantly lower than its peers). • Estimate the level of spending on PHC through national health accounts analysis and public expenditure reviews. • Increase allocation to PHC programmes and initiatives in national health plans and medium-term expenditure frameworks. • Strengthen public financial management systems to monitor spending on PHC and minimize wastage and abuse.
At sub-national level
• Minimize disparities in allocations and spending between primary and tertiary care and inequalities in PHC allocations to districts. • Develop capacity at sub-national level to monitor costs and improve utilization of health services for greater efficiency.
By people and communities
• Advocate increased transparency with regard to PHC expenditure, improved efficiency in spending existing allocations, and increased allocations. • Build capacity to monitor budget and expenditure review processes. • Form alliances with civil society groups that conduct broad-based (that is, non-health sector specific) reviews of budgets and expenditures.

2.4 Engagement of communities and other stakeholders

Engagement of communities and other stakeholders from all sectors to define problems and solutions and prioritize actions through policy dialogue

The engagement of people, as individuals and communities, and stakeholders from across varying sectors to work together in defining health needs, identifying solutions and prioritizing action is central to PHC. Anchoring the pursuit of health in engaged communities brings to life the commitment to refocus PHC on people rather than diseases and to inform PHC through meaningful evidence and multisectoral efforts rather than narrow programmes or ideology.

There is a long history of attempting to ensure community engagement in development projects (for example, community-driven development, participatory learning and action, Arnstein's ladder of citizen participation), as well as more recent efforts to focus on solving local problems through efforts that are co-owned locally (for example, "doing development differently"). Within the health sector, numerous models and frameworks have been developed (see *(12)* for a scoping meta-review), including by WHO (*13*), the Primary Health Care Performance Initiative (PHCPI) (*14*) and UNICEF.

It is helpful to consider community engagement in three stages: in the governance of health systems, in planning and priority setting, and in the course of implementation. In each of these, the emphasis is on community engagement being a process rather than a single, discrete intervention. This process should be deeper than simply consulting with community members. It should extend to co-ownership and co-design and should position people as having a central role in defining their health needs, prioritizing solutions, and determining the allocation of resources for them.

For each of these three areas, there are a wide range of possible forms of community engagement and there is no single approach that will work everywhere. They can span everything from simple measures to solicit feedback (for example, suggestion boxes) to the active provision of input (for example, through community advisory boards) to more extensive involvement in steering the direction of health services and/or co-managing it (for example, through participation in governance bodies and/or in decision-making about the allocation of resources).

The approaches to be employed should be developed jointly with community members, rather than being decided upon for them. Creating an enabling environment that is characterized by a respectful relationship between community members and the health services and professionals working in them is critical to ensure this joint development. It may be necessary for governments to invest in building the capacity of communities in order for them to become full partners in these processes (including to ensure that they have a fuller understanding of the role and rights of communities and thus equipped to engage in areas such as reviewing data and setting priorities).

One of the practical challenges is that there is rarely a homogenous "community" with only one viewpoint on any given issue. Instead, there are often multiple constituencies with inconsistent or conflicting views, insufficient information and limited trust. This is unsurprising given the diversity of actors that make up the "community", which can include individual patients/users of health services and their families, and private sector constituencies (both for-profit and not-for-profit), including civil society organizations (for example, consumer groups, community-based, faith-based and nongovernmental organizations, and affiliate groups). Accommodating such a wide array of actors often requires a range of strategies and processes at multiple levels. This can include mobilization through both health-specific structures (for example, health committees, community advisory panels, patient advocacy groups, participatory research programmes, community health workers)

and broader groups (for example, village committees, women's groups, rural development associations).

Engagement of private sector constituencies involves risks because their interests and objectives are not always aligned to the public good. Potential challenges include unresolved conflicts of interest, regulatory capture and the abuse of market power. Even when the objectives are more closely aligned, such as with not-for-profit groups, governments may struggle to effectively harness these disparate efforts to help meet the health objectives of governments and populations. For instance, governments may have incomplete information about the not-for-profit providers or lack the governance to align the activities with national health systems and priorities. Finally, as part of the engagement process, it is important to be aware of the possibility that consumer groups may be captured by commercial interests (*15*).

As part of the engagement process, special efforts should be made to reach vulnerable and disadvantaged populations (including indigenous peoples) who have specific needs, but who often lack the resources to participate in traditional engagement mechanisms. The inclusion of these people requires flexibility and adaptable processes, as well as safe and trusting environments developed progressively through deliberate and sustained efforts. Another group that often requires special efforts to reach is young people, who also have distinct needs and may not be tied into normal community structures.

TABLE 5: ENGAGEMENT OF COMMUNITIES AND OTHER STAKEHOLDERS: ACTIONS AND INTERVENTIONS

At national level
• Collaborate with communities to identify and implement the best mechanisms to engage them in the processes of governance, planning and priority-setting (including resource allocation), and service delivery. • Make special efforts to engage parts of the community that might otherwise not be involved in community engagement activities, such as the vulnerable and disadvantaged and young people. • Promote health literacy in order to broaden the share of community members able to actively engage. • As appropriate, engage in capacity-building efforts to ensure that communities are aware of their roles and rights and have the tools and information necessary to participate fully. • Support efforts of communities to engage more actively by capturing and disseminating information about health system performance. • Develop training programmes for community engagement and integrate information necessary to participate fully into the national curricula on medical education. • Support efforts of communities to engage more actively by capturing and disseminating information about health system performance. • Develop training programmes for community engagement and integrate into the national curricula on health professional education.
At sub-national level
• Support the development of structures (for example, health committees) at district, town and village levels and support participation of all social groups in these structures. • Support efforts to foster dialogue between different elements of the community (for example, between community-based organizations and academia). • Develop community monitoring mechanisms for monitoring outbreaks, epidemics, and diseases of high priority (for example, between community-based organizations and academia). • Appoint focal points for community engagement in various sections of the ministry of health (for example, those responsible for planning, budgeting and monitoring) and in sub-national (for example, district) health committees.
By people and communities
• Advocate for community engagement in governance planning and priority setting and implementation. • Participate in mechanisms established to facilitate community engagement. • Consider forming associations or networks to enable a more representative engagement in governance, planning and priority setting, and implementation.

3. Operational levers

3.1 Models of care

Models of care that promote high-quality, people-centred primary care and essential public health functions as the core of integrated health services throughout the course of life

A model of care is a particular arrangement of structural elements (governance, financing, workforce, physical environment, information systems and other technologies) and processes of care, ideally supported by an explicit identification of roles and the allocation of responsibility and tasks along the pathways of care. Different models of care can co-exist in one health system and be used for delivering the various required functions in a health system. Innovations in models of care delivery, such as those facilitated by technological solutions using "eHealth" (see Section 3.8), can facilitate continuous improvement in the responsiveness and efficiency of the system.

Models of care must be tailored to local contexts as what is required and feasible will inevitably differ between what works best in a humanitarian setting and an upper-middle income country. However, there are some principles that are common across all settings. First, models of care should promote a comprehensive vision of PHC to deliver integrated health services. This involves focusing on the system functions and core outcomes that are consistent with the PHC orientation in a particular setting, including ensuring that population-based services are adequately prioritized and that there is a good coordination between public health and primary care. Second, at the level of individual health care services, health systems need to be reoriented to ensure that primary care is both the first and regular point of contact and at the core of the health system, linked to all other levels of care and services through functioning referral systems from frontline services to hospital-based care (sometimes described as the "gatekeeping" function of primary care). Third, models of care should be continuous, comprehensive, coordinated and people-centred, rather than focused on specific diseases (particularly in light of the growing recognition of the importance of addressing multi-morbidity). Finally, models of care should recognize the crucial role of PHC in addressing both existing and emerging health problems (including the shifting disease burdens that many countries face as communicable diseases are better controlled, but non-communicable ones become more prevalent).

An important strategy for ensuring that models of care adopt a PHC orientation is the use of multidisciplinary teams (also discussed in Section 3.5). There is not a single model for these teams, but they typically combine a range of skills and professions, such as community health workers, nurses, family doctors, pharmacists, dieticians and management/administrative staff, in order to be able to address the full needs of the individuals they serve. Connecting community health workers with facility-based staff is a particularly important aspect, both to improve the quality of care offered by the former and because they can play a vital role in linking communities to facilities and delivering population-based services. Governance, accountability, and financing for results across the care pathway in models of care involving multiple providers are critical enablers *(16–22)*.

Another common strategy is to entrust the health of defined geographical communities to specific teams through the process of empanelment (assigning individual patients to individual primary care providers). This encourages the providers/teams to take responsibility for a holistic approach to the health of the people under their care, which facilitates in delivering both public health and primary care functions.

With regard to the challenge of integrating public health and primary care functions, a number of different strategies have been used. A review prepared for the Astana Conference identified six models (*23*):

1. public health professionals integrated into primary care
2. public health services and primary care providers working together
3. comprehensive and proactive benefit packages that include public health
4. primary care services within public health settings
5. building public health incentives in primary care
6. multidisciplinary training of primary care staff in public health.

When designing new models of care that promote integrated health services, it is important to examine the possibilities opened up by new technologies. For example, if both community health workers and facility-based staff have access to a patient's electronic health records, updates about the patient can be shared in real-time, thus facilitating holistic models of care to ensure that all health personnel are providing complementary, reinforcing information and improving the quality of care.

TABLE 6: MODELS OF CARE: ACTIONS AND INTERVENTIONS

At policy level
• Develop models of care that are suited to the situation of the country, but ones that advance the key principles of promoting comprehensive integrated health services (including combining public health and primary care), placing primary care as the first and regular point of contact, ensuring that care is continuous, comprehensive, coordinated and people-centred, and addressing both existing and emerging issues. • Ensure that policy frameworks are updated to reflect the evidence about successful models of care, such as the importance of connecting community health workers with facility-based staff. • Consider adopting new technologies that can facilitate holistic models of care. • Support the development of new models of care through targeted training programmes for health professionals and policy-makers. • Develop and strengthen information systems for the monitoring and facilitating of the evaluation of models of care and benchmarking.
At operational level
• Support the development of local leadership and empowerment within models of care suited to local needs. • Formalize collaborative relationships within multidisciplinary teams. • Establish referral systems that ensure that primary care facilities (as the first point of contact for most people) can refer seamlessly to other levels of care.
By people and communities
• Advocate for models of care that embody key PHC principles. • Participate in designing new models of care and reviewing their performance.

3.2 Primary health care workforce

An adequate quantity, competency levels and distribution of a committed multidisciplinary primary health care workforce that includes facility-, outreach-, and community-based health workers supported through effective management supervision and appropriate compensation

The PHC workforce includes all occupations engaged in the continuum of promotion, prevention, treatment, rehabilitation and palliative care, including the public health workforce and those engaged in addressing the social determinants of health. It also includes caregivers, the majority of whom are women, complementing the actions of salaried workers *(24)*. Beyond service provision, health workers also include management/administrative staff who are critical for the functioning of the health system across different care settings, for example, information officers and planners. Health workers are the critical pathway to attaining the targets in SDG 3 and other health-related SDGs. An adequate, well-distributed, motivated, enabled and supported health workforce is required for strengthening PHC and progressing towards universal health coverage.

According to 2013 data, estimates show a projected global shortfall of 18 million health workers to achieve and sustain universal health coverage by 2030, primarily in low- and lower-middle-income countries, including 2.6 million doctors, 9 million nurses and midwives, and 5.9 million representing other health worker categories *(25)*.

While improving the availability and distribution of PHC workers where there are shortages is essential, it is also important to improve the productivity and performance of the existing workforce. Adopting a diverse, sustainable skills mix geared to PHC, including proper links through all levels of care to the social services workforce, ensures a more effective and efficient use of resources while better aligning to community needs. In some contexts, this includes harnessing the potential of community health workers operating in inter-professional primary care teams.

The Global Strategy on Human Resources for Health: Workforce 2030 and the recommendations of the United Nations High Level Commission on Health Employment and Economic Growth provide the strategic orientation and policy options for strengthening the health and social workforce for PHC, universal health coverage and the SDGs.

The four objectives of the Global Strategy on Human Resources for Health: Workforce 2030 (*26*) have a direct bearing on the PHC workforce:

- optimize performance, quality and impact of the health workforce through evidence-informed policies on human resources for health;
- align investment in human resources for health with the current and future needs of the population and health systems, taking account of labour market dynamics and education policies;
- build the capacity of institutions at sub-national, national, regional and global levels for effective public policy stewardship, leadership and governance of actions on human resources for health;
- strengthen data on human resources for health for the monitoring and accountability of national and regional strategies, including the Global Strategy.

Meeting these objectives will require concerted efforts and accountability to meet multiple key challenges, including ensuring sufficient availability and distribution of health workers, improving productivity and performance for a better quality of care, and enhancing the management and utilization of human resources.

The need to address each of these factors differs across countries. The starting point for effective health workforce planning is to understand the health labour market dynamics based on a robust evidence base to ensure adequate skilled health workers. This requires an understanding of the current and future profile of the health and social workforce (stock, distribution, skill mix, education, regulation, inflow/outflow, working conditions and remuneration). Responding to these challenges also requires a multisectoral effort, including engaging with the education, labour, and finance sectors.

When assessing the availability and distribution of the health workforce, it is important to take a holistic view and recognize that a multidisciplinary team (also discussed in Section 3.2) is often the best way to deliver care. Delivering primary care through well-functioning, multidisciplinary teams requires optimizing health workers' skill mix. There is no ideal model for these teams as each country organizes its health and social workforce based on its own context, resource availability and investment capacity. In some countries, PHC strategies are based on physician-led models, whether be a general physician or a family doctor, as they have a comprehensive generalist skill set that is critical for addressing the range of issues that arise in primary care. Other countries may opt to have a more diverse composition of primary care teams that could include paramedical staff, nurse practitioners and community health workers, in addition to doctors. In some instances, where available resources and skills are overstretched, optimizing the skill mix could be achieved by reorganizing scopes of practice (often referred to in the literature as "task-shifting", "task-sharing", "delegation" or "substitution"), by which non-statutory tasks performed by a specific occupation may be expanded to other occupations through additional training and are regulated to ensure safe practice.

Given the multisectoral nature of PHC, it is also important to consider how professions in other sectors can be involved, such as water and sanitation, education and the environment, as well as those with a particular expertise in engaging people and communities, such as community development specialists or anthropologists.

It is important to recognize that the issues associated with producing, deploying and retaining each of the types of health workers may differ and so require different solutions. One particularly common challenge is the recruitment and retention of community health workers. Some countries have improved this by formalizing their role, including by paying and integrating them into PHC systems (for example, by connecting them to health facilities), but this is not yet the norm for all community health worker programmes. WHO guidelines on health policy and system support to optimize community-based health worker programmes provides additional evidence on integrating community health workers in health systems.

While improving the availability and distribution of workers is essential, it is also important to improve processes and accountability to maximize the utilization, productivity and performance of the existing workforce. Apart from inappropriate skill mix and unclear roles and expectations, performance constraints also include competency gaps, insufficient motivation, inadequate compensation and unsuitable incentives, weak supervision and work processes, unclear guidelines, and difficult work environments. Thus, even where there are no critical workforce shortages, health workers may still fail to provide quality care *(27)*. Section 3.3 has already addressed a number of aspects of improving quality of care, but it is also the case that simple improvements in the management of human resources for health can frequently pay big dividends. Steps such as defining roles and responsibilities within a multidisciplinary team, improving communications, ending discriminatory practices and behaviour, balancing workloads and providing supervision and feedback are basic functions of good human resources management that are too often not done

systematically. Investing in building management capacity among health workers and administrative staff can be an important way to improve performance.

In most countries, well-chosen interventions can help achieve quick wins and address critical bottlenecks. However, developing a fit-for-purpose PHC workforce, especially in countries facing critical shortages, requires a medium- to long-term strategic response, although some short-term interventions can also help to achieve quick wins. A concerted response at the national, sub-national and community levels with the support of global and regional development partners can help accelerate progress towards an adequate, competent, well distributed and multidisciplinary PHC workforce.

TABLE 7: PRIMARY HEALTH CARE WORKFORCE: ACTIONS AND INTERVENTIONS

At policy level
• Develop evidence-based health workforce policies, strategies and plans that prioritize investments in the PHC workforce to meet community and population needs. • Establish appropriate forums or intersectoral coordination mechanisms that engage ministries of education, labour, finance and planning to ensure the alignment of different constituencies and stakeholders around issues of health workforce education, skills, employment and remuneration (including supporting these ministries to incorporate the needs of health workers into their own sectoral plans). • Mobilize adequate funding from domestic and donor sources to sustain the supply, recruitment, deployment and retention of PHC workforce and minimize premature exit. • Improve the distribution of the workforce through appropriate strategies (for example, regulations, financial and non-financial incentives, education) to deploy PHC workers in underserved communities and facilities. • Align health worker education and skills to community and population needs and strengthen education and training institutions to scale-up and sustain the production of PHC workers in appropriate quantity, quality, and relevance to respond to current and future health priorities. • Reorganize scopes of practice, if needed, to expand access to critical services and optimize primary care delivery. • Strengthen governance capability of national regulatory authorities to appropriately regulate health professional education and practice, including public and private sector actors. • Support the development of professional bodies that can engage actively in policy dialogue and provide an oversight.
At operational level
• Ensure that PHC health workers have the core competencies required to deliver the defined package of health services. • Institutionalize interprofessional continuing education and training for PHC teams to ensure that they are enabled and equipped with broad-based, and up-to-date skills. • Establish management processes and accountability for optimizing motivation, satisfaction, retention and performance. • Promote decent work that ensures gender-sensitive employment free of violence, discrimination and harassment, manageable workloads, adequate remuneration and incentives, and occupational health and safety. • Develop and apply job descriptions for all PHC workforce occupations with appropriate competencies, expectations and key tasks, linked with merit-based recruitment, deployment, performance and progression.

- Provide career development opportunities through job security, supportive supervision, and career development pathways (including for community health workers).
- Strengthen health workforce information systems and/or implementing national health workforce accounts in order to inform policy and planning and strengthen monitoring of performance.

By people and communities

- Enhance accountability of PHC staff at community-, outreach- and facility levels through regular monitoring and feedback on performance.
- Ensure representation of PHC staff on professional bodies.
- Participate in the selection and deployment of staff at community-, outreach- and facility levels.

3.3 Physical infrastructure

Secure and accessible primary care facilities to provide effective services with reliable water, sanitation and waste disposal/recycling, telecommunications connectivity and a power supply, including transport systems that can connect patients to other care providers

The physical infrastructure of PHC, such as clinics and health centres, is often overlooked and neglected, but it has an important impact both on the ability of healthcare providers to do their jobs and on patient satisfaction, which in turn tends to affect the use of health services (*28*). Key elements of the facility physical infrastructure include having reliable water, sanitation and waste disposal/recycling, telecommunications connectivity and power supply.

Effective infection prevention and control measures and water, sanitation and hygiene (WASH) services in health care facilities are the foundations of quality, safe health care. Without these, patients are placed at higher risk of acquiring infections while seeking care and antimicrobial resistance (AMR) will continue to present a threat to PHC, thus resulting in infections that are more difficult and expensive to treat. Effective infection prevention and control and WASH systems ensure that all services are provided in a clean and safe environment. Such services not only improve quality of care, but are the basis for preventing AMR by reducing certain practices, such as the prophylactic use of antibiotics before child delivery. Furthermore, safe treatment and disposal of fecal waste is important for preventing the spread of AMR in the environment. In addition, the cleanliness of facilities and the availability and functionality of specific services, such as toilets and drinking water, has an impact on those seeking care and patient satisfaction.

Facilities should have water and sanitation services available for all users, including patient family members. They should meet national standards and be regularly maintained with sufficient, skilled staff to keep them functioning and clean. Particular attention should be paid to ensuring that people with a wide range of abilities can use PHC facilities. Telecommunications connectivity is becoming an increasingly indispensable aspect of the physical infrastructure for PHC. Many countries rely on electronic systems for data collection, such as the District Health information System 2 (DHIS2), a free and open source health management data platform used by multiple organizations, including numerous governments, and currently being deployed in 54 countries (see Section 3.11). Thus, workers at facilities without connectivity may not be able to report regularly or may have to rely on their own personal technology. Additionally, as discussed in Section 3.8, advances in digital technology hold considerable promise for improving PHC services, but these potential benefits will be significantly undermined if facilities are unable to offer reliable connectivity to support initiatives, such as telemedicine, e-learning or electronic health records.

A reliable power supply is needed for telecommunications connectivity, but it is also essential for a wide range of other purposes, including to ensure adequate lighting for diagnosis and medical procedures and to ensure the functioning of refrigerators necessary to maintain cold chains. This has become considerably more feasible in recent years as an off-grid power supply, particularly through solar panels, has become more affordable and easier to install.

The final aspect of the physical infrastructure is transport, particularly the ability to move patients who required more advanced care than can be delivered at primary care level to secondary or tertiary facilities. The lack of transport can act as a significant barrier to care and can exacerbate inequalities and is therefore a critical aspect of the overall PHC infrastructure. There are a number of possible ways that local officials can approach this, including direct ownership of vehicles (for example, ambulances), partnerships with private transport providers, or via vouchers that subsidize the cost of private transport.

TABLE 8: PHYSICAL INFRASTRUCTURE: ACTIONS AND INTERVENTIONS

At policy level
• Establish national standards for infection prevention and control. • Develop implementation plans to ensure that all health facilities have WASH systems, telecommunications connectivity and a power supply. • Develop policies that promote access to health facilities for people of all abilities.
At operational level
• Ensure that all newly-constructed health facilities have reliable WASH systems, telecommunications connectivity and a power supply. • Ensure proper management and maintenance of health facilities, prioritizing reliable infection prevention and control and WASH systems, telecommunications connectivity, and a power supply. • Establish protocols to ensure gender-sensitive facilities that are free of violence, discrimination and harassment. • Develop an approach that ensures that transport is not a barrier to accessing services.
By people and communities
• Use established mechanisms to facilitate reporting on health facility standards and functions (for example, citizens' scorecards).

3.4 Medicines and other health products

Availability and affordability of appropriate, safe, effective, quality medicines and other health products through transparent processes

PHC relies on access to products including medicines, vaccines, medical devices, diagnostics, protective equipment and assistive devices. These must be of assured safety, efficacy/performance and quality. In addition, they must be appropriate, available and affordable.

National regulatory authorities are responsible for ensuring safety, efficacy/performance and quality of health products at all levels of the health system. Registration or marketing authorization of health products is a key regulatory step to allow health products into a country. National regulatory authorities are responsible for ensuring that health products are stored, distributed and dispensed appropriately. With regard to PHC, this entails the licencing of establishments, such as storage facilities or pharmacies. Sub-standard drugs are estimated to be responsible for hundreds of thousands of deaths each year *(29)* so post-market surveillance at all levels is essential to ensure the safety and performance of health products. If medicines cause a serious adverse event or a medical device does not perform as expected, it is important to report back to the national regulatory authorities so that the benefits and risks of the issue can be assessed and action taken if needed.

Ensuring that appropriate health products are available and affordable depends upon a number of policy decisions and processes related to the selection, pricing, procurement, supply chain management, maintenance (in the case of medical devices), prescribing and dispensing (in the case of medicines) and use of health products.

Procurement of health products should be guided by evidence-based selection processes, such as a health technology assessment (systematic assessment of the properties, effects and impacts of a health technology) *(30)*. It is a multidisciplinary process that evaluates the social, economic, organizational and ethical issues related to health technology, informing decisions on when, where and how it can be used. Global guidelines, such as lists of essential medicines, vaccines, medical devices and associated procedures, are useful in determining which health technology is appropriate for local assessment to support services in primary care (for example, *[31]*).

While these processes occur at the national level, it is essential to consider the context for PHC. Good procurement practice and policies that favour the purchase of generic medicines play a key role in ensuring quality products at affordable prices. This will support the effective use of government resources and contribute to the reduction of out-of-pocket expenditure for patients.

Good supply chain management ensures that quality products are available at all levels of the health system. Supply chain management competencies that are particularly required at the PHC level include stock management and maintenance (of medical devices). A key dimension to this is ensuring the availability of health products during an outbreak, a natural disaster, or other emergency. This is becoming increasingly critical as extreme events become more common as a result of climate change and it is important to build the resilience of supply chains (*32*). Reliable tracking of products is a key dimension of good supply chain management and a number of countries have deployed logistics management information systems to ensure the ready availability of information about health products. Good supply chain management for PHC should encompass not only facilities, but also health products used by community health workers.

Maintenance of health products is also a critical issue, particularly medical devices. This often requires specialized skills that may not be readily available at primary care level and regular communications with higher authorities is important. It is important to ensure that health workers

have the necessary competencies for the implementation of clinical practice guidelines, appropriate prescribing and dispensing of medicines, and use of medical devices. This is essential to protect both individual patients and public health in general as the spread of AMR poses an increasingly major threat.

Finally, although this section has focused primarily on health products, PHC also draws on a number of products from outside the health sector. Food-related technologies are particularly important, including those for the preparation of food such as cooking stoves that do not contribute to air pollution. Products to ensure safe drinking water are also critical for PHC.

TABLE 9: MEDICINES AND OTHER HEALTH PRODUCTS TO IMPROVE HEALTH: ACTIONS AND INTERVENTIONS

At policy level
• Strengthen national regulatory bodies to ensure safety, effectiveness/performance and quality, including by using the WHO Global Benchmarking Tool for the formulation of institutional development plans. • Engage in collaborative approaches to the registration of health products. • Use evidence-based selection methods, including health technology assessments, to guide procurement and reimbursement decisions. • Establish pricing policies to make full use of generics and other procurement strategies that maximize resources and reduce out-of-pocket payments. • Strengthen supply chain management to ensure availability of health products (including maintenance of medical devices) at the point of use. • Ensure adequate domestic resources to access health products appropriate to primary care. • Ensure national capacity to prepare for and respond to the needs for health products in emergency situations, including diagnostics, personal protective equipment and medicines.
At operational level
• Implement technical guidelines, norms and standards for quality assurance and the safety of health products. • Strengthen governance and oversight, including on the efficiency and integrity of the supply chain. • Ensure capacities for the appropriate prescribing, dispensing and use of medicines, as well as the correct management and maintenance of medical devices, especially before new products are introduced. • Undertake periodic random surveys of storage, availability and quality of health products. • Ensure the maintenance of health products (particularly medical devices). • Establish the local capacity to mobilize health technology during health emergencies, including personal protective equipment needed.
By people and communities
• Participate in decision making around the adoption of new health technologies. • Participate in the monitoring of price, availability, safety and quality of health products.

3.5 Engagement with private sector providers

Sound partnership between public and private sector providers for the delivery of integrated health services

In the health area, the private sector refers to all non-state actors involved in health: profit/not-for-profit entities, formal/informal, domestic and international. Almost all countries have mixed health systems with goods and services provided by the public and private sector and health consumers requesting these services from both sectors. The private sector's involvement in health systems is significant in scale and scope and includes the provision of health-related services, medicines and other health products, health insurance, supply chain management, training for the health workforce, information technology, as well as infrastructure and support services.

The term "private sector" covers a wide array of actors and services across the health system, including as a source of financing, a developer of new technologies and products, a manager of supply chains, an advocate, and a service provider *(33)*. This means that engagement with the private sector is included in many of the levers. However, this lever does not attempt to aggregate all of these, but rather focuses specifically on one of the most important dimensions, the role of private sector providers in service delivery.

This is a critical area because virtually every country has a mixed health system that includes both public and private provision of care. In many countries, a significant share of primary care services is delivered by the private sector. The share varies by the particular service in question, but frequently exceeds 50% in many low- and middle-income countries *(33–36)*. In the context of primary care, this typically includes provision by a range of actors, including individual doctors, traditional medicine practitioners, pharmacists, dieticians or others running informal drug shops, and non-profit providers (such as faith-based or nongovernmental organizations). Additionally, a number of companies provide occupational health services to their employees. While these programmes are typically aimed at health and safety at work, they often end up providing primary care to workers (and their families).

It is important to highlight that in most countries the public and private sectors are not hermetically sealed off from each other. Individual health professionals may practise in both and a significant share of patients seek services from both (sometimes for the same condition). Moreover, actions that are aimed at one sector (for example, improving the quality of care in public facilities) often end up influencing the other sector (for example, by shifting the demand from lower-quality private providers to the public sector) *(33, 37)*.

A number of approaches and tools can be employed to ensure successful collaboration. At the level of policy development, the private sector should be treated as a constituency that can bring relevant expertise and it is often valuable to invite private sector representatives to participate in designing relevant strategies and policies. The Joint Learning Network for Universal Health Coverage (JLN) has identified five key steps to strengthening dialogue with the private sector, including finding common ground ("win-wins") and establishing a regular consultative process *(38)*.

Of note, there is a potential for conflicts of interest (for example, by pushing a national policy shift that ends up benefitting a commercial interest) and it is important for national authorities to be alert to this possibility and to take steps to minimize it. For example, by working with trade associations or networks that may be less likely to have conflicts and by ensuring complete transparency in all engagements with the private sector.

With regard to engaging the private sector in the delivery of care, one framework (*39*) highlights four possible approaches:

- prohibition: the banning of some or all forms of private practice, such as the prohibition of unlicensed providers; in practice, bans are uncommon because they are often difficult to enforce;
- constraint: while outright bans are rare, most countries place some constraints on private providers, typically in the form of regulations such as statutory controls, accreditation, or self-regulation by professional bodies; these cover areas such as human resources, medicines, facilities, and equipment;
- encouragement and subsidization: many countries seek to incentivize the private sector to improve access to services and/or their quality; a range of mechanisms are used for this purpose, including public-private partnerships, social franchising, social marketing, and the provision of training and/or other support to improve the quality of care;
- purchasing: many governments contract private providers for some elements of service delivery (for example, laboratory and/or medical equipment services, supply chain management for medicines), while a number also use voucher programmes to target subsidies at particular populations (for example, to reduce financial barriers to disadvantaged populations accessing maternal and child health services).

In any given country, it is typically the case that multiple approaches will be employed at the same time to address different aspects of engagement with the private sector. To assist with this, WHO has developed a decision-making model and a set of tools designed to provide the information needed to support evidence-based decision-making, including:

- understanding a country's health markets, types of private actors, and the nature and scale of private activity
- identifying potential areas of risk and opportunity posed by the private sector to a country's health goals
- assessing governance and regulatory capacity, matching this capacity to its envisioned role for the private sector, and helping with the design of reforms to address capacity gaps
- identifying different modes of control or engagement of the private sector.

The framework and model aim to help countries formulate policy on the private sector and choose and deploy legal and financial policy tools to implement it.

To address the fact that many countries do not have an accurate sense of the scope of private sector provision, the JLN has also produced a step-by-step guide to mapping private sector providers, which is critical to ensuring an adequate information base for decision-making *(38)*. A somewhat broader approach to conducting private sector assessments has been developed by the United States of America government-supported SHOPS and SHOPS Plus projects, which have conducted assessments in more than two dozen countries and prepared a guide to carrying out assessments based on this experience *(40)*.

Finally, it is also important to ensure the participation of private providers in national monitoring and evaluation efforts, ideally including through health management information systems, such as the DHIS2. This has proven challenging in a number of countries *(41)*, but new technologies are creating opportunities for stronger collaboration around monitoring systems and private sector actors and networks should hold themselves accountable for participating in national systems.

TABLE 10: ENGAGEMENT WITH PRIVATE SECTOR PROVIDERS: ACTIONS AND INTERVENTIONS

At policy level
• Develop an approach to engaging with the private sector around policy development (for example, through a regular consultative engagement process or platform), including how to manage conflicts of interest. • Identify particular challenges (for example, elements of service delivery that are lagging) and assess whether greater private sector engagement could improve performance. • Develop the approach (for example, constraint, encouragement, purchasing) for engaging with the private sector that is best suited to addressing the challenge identified. • Assess legal and regulatory frameworks to ensure that they adequately address the private sector, including with regard to issues of accountability. • Conduct provider mapping or a private sector assessment to ensure accurate information about the scope of private sector service delivery. • Proactively reach out to private providers to ensure inclusion in national monitoring and evaluation systems.
At operational level
• Strengthen capacity to conduct oversight/control of the private sector according to laws and regulations. • If appropriate and given the extent of decentralization, develop an approach to engaging with the private sector around policy development (for example, through a regular consultative engagement process or platform), including how to manage conflicts of interest.
By people and communities
• Organize alliances or networks that can improve the representation of the private sector in policy dialogue with the government. • Engage actively in existing policy-making bodies. • Contribute data to health information systems.

3.6 Purchasing and payment systems

Purchasing and payment systems that foster a reorientation in models of care towards more prevention and promotion and towards care delivered closer to where people live and work. Such systems provide incentives for the delivery of high-quality primary care services and facilitate integration and coordination across the continuum of care

PHC-oriented purchasing and payment systems can serve as important tools for addressing issues of access, quality and equity in health care. Many low- and middle-income countries find it challenging to improve PHC due to underprovision of high-priority services, overreliance on hospitals to deliver services that are more appropriately delivered in primary care, poorly functioning referral systems, difficulty in managing costs, inefficient allocation of limited resources, obstacles to effectively engaging private sector providers, and lack of monitoring and performance measurement. Well thought out purchasing and payment models allow adequate resources to flow in support of PHC-orientation and increase the accessibility of priority interventions to the entire population. These models can also create incentives across the health system to manage population health, use resources efficiently, and avoid unnecessary services and expenditure at the secondary and tertiary levels *(42)*.

Strategic purchasing and payment mechanisms – including benefits design, provider payment methods and contracting arrangements – can strengthen PHC-orientation and advance other health system objectives. In particular, they can be used as tools to orient models of care around PHC and promote the delivery of integrated health services.

To inform payment models, comprehensive and integrated benefit packages must be developed that highlight the full spectrum of population-wide and individual-based services and interventions throughout the course of life. By considering promotive, protective, preventive, curative, rehabilitative and palliative care services, packages can guide role delineation and coordination of health services across levels of the health system, and as such, can improve the effective and efficient allocation of PHC resources. The use of primary care services, for example, might be incentivized through preferential reimbursement or through the reduction or elimination of out-of-pocket spending in primary care settings. Benefits design should always involve the participation of people and communities, including providers and purchasers, and should aim to promote equity and leave no one behind.

The way in which providers are paid is also known to have a profound impact on the volume and quality of health services delivered. Designing and implementing appropriate provider payment methods can provide the right incentives to promote integrated health services centred around primary care and public health. Introducing innovative provider payment methods is assuming a greater importance as PHC-oriented systems are increasingly being led by family physicians in low- and middle-income countries and as countries are moving away from charging user fees. The latter have become less popular as it has become clearer that they have significant negative effects on poorer populations and worsen inequality. The most commonly used provider payment methods include a line item budget (staff salary being the line item), global budget, fee for service, capitation (per capita payment), per diem, and case-based payment (for example, diagnosis-related groups). The first four are more relevant to paying primary care providers and are explained in Table 11.

TABLE 11: ASSESSMENT OF PROVIDER PAYMENT METHODS

Payment method	Definition	Incentives for providers	When the method may be useful
Line item budget	• Providers receive a fixed amount for a specified period to cover input expenses (for example, personnel, medicines, utilities)	• Underprovided services increase referrals, increase input, spend all remaining funds by the end of the budget year • No incentive or mechanism to improve efficiency	• Management capacity of the purchaser and providers is low; cost control is a top priority
Global budget	• Providers receive a fixed amount for a specified period to cover aggregate expenditures to provide an agreed-upon set of services • Budget is flexible and not tied to line items	• Global budgets formed based on input: underprovide services, increase referrals, increase input • Global budgets formed based on volume: increase the number of services, increase referrals, decrease input (possible efficiency)	• Management capacity of the purchaser and provider is at least moderate; competition among providers is not possible or not an objective; cost control is a top priority
Fee for service	• Providers are paid for each individual service • Fees are fixed in advance for each service or group of services	• Increase the number of services, including above the necessary level; reduce input per service, which may improve the efficiency of the input mix	• Increased productivity, service supply and access are top priorities; there is a need to retain or attract more providers; cost control is a low priority
Capitation (per capita)	• Providers are paid a fixed amount in advance to provide a defined set of services for each enrolled individual for a fixed period of time	• Improve efficiency of the input mix, attract enrollees, decrease input, underprovide services, increase referrals, improve output mix (focus on less expensive health promotion and prevention), attempt to select healthier (less costly) enrollees	• Management capacity of the purchaser is moderate to advanced; strengthening primary care and equity are objectives; cost control is a priority; choice and competition are possible

Source: Adapted from Langenbrunner, Cashin and O'Dougherty *(43)*.

While there is no ideal payment method and each model has its strengths and weaknesses, many countries are moving towards blended payment models that include capitation and fee-for-service payment. This is both because they are the most consistent with the philosophy of PHC (encouraging population-based management and productivity and as the alternatives have demonstrated shortcomings in supporting a PHC-centred health system. Capitation is structured around paying for a defined set of services for a defined catchment area population (or for the people affiliated to that facility) and period of time, rather than tying payment to specific diagnostic and curative services when those services are delivered, and so it is often linked to empanelment (see Section 3.2).

A growing number of new provider payment models are emerging, which explicitly seek to align payment incentives with health system objectives related to care coordination, quality, health improvement, and efficiency by rewarding the achievement of targeted performance measures. These have become collectively known as "pay for performance" (P4P). For instance, a P4P model may aim to support the integration and coordination of care across the health system by incentivizing primary care providers to deliver more promotive, protective, or preventive services, while incentivizing other care providers to redirect frontline services to primary care settings closer to the community. The data on the impact of P4P mechanisms on health outcomes are mixed. Their most important contributions may be their reinforcing effects on broader performance improvement initiatives and their spillover effects or other health system strengthening that occurs as a by-product of the incentive programmes *(44)*. Contracting is another useful purchasing mechanism to drive PHC by generating provider accountability to PHC-related goals and objectives. Contracting terms, for example, might be designed to link payments to the successful achievement of national and/or local health outcomes, or to support the creation, expansion and management of integrated provider networks based on community needs.

Adequate data are critical to well-functioning purchasing and payment systems, so strengthening monitoring capacity should be included in any strategic purchasing reform (*45*).

TABLE 12: PURCHASING AND PAYMENT SYSTEMS: ACTIONS AND INTERVENTIONS

At policy level
• Develop an inclusive strategic approach to provider payment and contracting in all care settings as part of the wider health financing and strategic purchasing strategy, with the view to reorient models of care toward primary care and support coordination and integration. • Define a comprehensive benefit package that includes promotive, protective, preventive, curative, rehabilitative and palliative care services before selecting payment methods. • Strengthen monitoring systems to ensure that purchasing and payment mechanisms are based on robust data. • Use a combination of costing and other information to match resources to the comprehensive benefit package.
At operational level
• Ensure appropriate role delineation based on agreed models of care and available resources. • Support continuous improvement of purchasing and payment systems through regular monitoring of the incentives and possibly adjustment/s to the payment method. • Promote transparency by releasing data on budgets and expenditures to the maximum extent.
By people and communities
• Participate in the design and development of national strategic purchasing strategies, benefits design, and contracting. • Monitor facility or provider performance to ensure desired quality of care that minimizes under- or overprovision • To the extent possible, avoid making under-the-table payments or unnecessarily high of co-payments for primary care services.

3.7 Digital technologies for health

Use of digital technologies for health in ways that facilitate access to care and service delivery, improve effectiveness and efficiency, and promote accountability

Digital technologies — particularly information and communication technology (ICT), but also areas such as "big data", artificial intelligence and genomics — have changed dramatically in recent decades, with advances such as the Internet and mobile telephony spreading far more rapidly than earlier technologies. Although access is not yet universal, more than 8 in 10 people in developing countries own a mobile phone and nearly half of the global population uses the Internet. These technologies are more equitably distributed across the planet than income in that even the region with the lowest mobile penetration — sub-Saharan Africa — has 78 mobile cell subscriptions per 100 people (*46, 47*)

The ICT revolution has brought about important shifts in how individuals and communities manage their own health and access information about health conditions, treatment options and the availability (and sometimes quality) of service providers. This can play an important role in advancing the core PHC tenet of empowering people and communities by putting new power in the hands of people and shifting the nature of the relationship between medical provider and patient by reducing the asymmetry of information. However, too much of the information currently available is only in English or other languages that are typically not the first language of people in low- and middle-income countries, which is limiting the impact of the ICT revolution in these settings. Additionally, new technologies are creating new ways that people can hold service providers to account, as well as enabling more effective and larger-scale advocacy and health promotion efforts.

New technologies are also having profound effects on the provision of primary care services, particularly through the rapid expansion of digital health interventions, particularly "mHealth" (mobile health) and "eHealth" (electronic health) initiatives. Governments have rapidly responded to this changing landscape by developing national strategies or plans for these types of interventions, the number of which has increased from under 20 a decade ago to nearly 60 as of 2016 *(48, 49)*.

WHO has classified digital health interventions into four categories (*50*):

1. for clients (for example, targeted client communication, such as reminders, peer communications, personal health tracking, citizen reporting);
2. for health workers (for example, client identification and registration, health records, decision support tools, telemedicine, referral coordination, training, prescription and/or diagnostics management);
3. for health systems' managers (for example, human resources management, supply chain management, civil registration and vital statistics);
4. for data services (for example, data collection, management and use, location mapping, data exchange).

WHO has recently completed an extensive review of the evidence for digital health interventions (*51*). The evidence for the effectiveness of many interventions is still limited, but 10 recommendations were made, most of which highlighted that currently the interventions could only be recommended in certain situations, such as when standard operating procedures and data privacy standards were in place.

Despite the limited evidence base, digital health interventions have been expanding rapidly as they are perceived to offer ways to address key health system challenges, a number of which are highly relevant for PHC. For example, an increasing number of countries are attempting to address human

resources' constraints across the health system, through e-learning or telemedicine, particularly in relation to primary care. The former aims to build capacity among health workers through electronic courses or other forms of pre- and in-service training. These can reduce the cost of training, improve access to expertise, and enable access to training in settings that have limited educational facilities.

Telemedicine can provide access to specialist expertise by transmitting medical images and clinical data or descriptions to off-site facilities that support diagnosis and can propose treatment options. Areas of focus so far include radiology, dermatology, pathology and psychiatry, but improvements in mobile phone technology are expanding the range of services that can be offered, including in new areas such as cardiology and ophthalmology. The impact of these is particularly important in primary care, given the ways in which they can dramatically increase the capacity of health personnel who have a limited medical education (for example, community health workers). However, it is also important to note that telemedicine requires medical technologies at both ends and involves specific concerns related to data management and legal responsibilities between the practitioner on-site and the specialist off-site. Other technologies are further away from widespread use in low- and middle-income countries, but are likely to have a major impact in the coming years. For example, artificial intelligence is already starting to be used to improve diagnoses, while personalized genomics has the potential to enable tailored treatment approaches.

Advances in ICT have already shaken up health information systems and the traditional paper-based systems have been partially or fully replaced by electronic systems for collecting, coding and aggregating data in many countries, resulting in significant improvements in the timeliness and accuracy of information systems, particularly through the DHIS2 platform (*52*). Electronic health records are less widespread, but WHO reports a nearly 50% increase in the use of these systems in the past five years *(48)*. Ensuring legislation to protect confidentiality is an important component of electronic health records, but has lagged behind in a number of countries.

Two other emerging applications of ICT that are particularly relevant to PHC are the ability to use "big data" approaches to analyse patterns and trends and efforts use data to improve the targeting of public health efforts (sometimes called "precision public health"). New technologies have already made an impact in supply chain management (for example, through electronic logistics management information systems) and there are efforts underway to use cutting-edge approaches, such as blockchain technology to improve the reliability of supply chains.

ICT is increasingly embedded in new medical devices, enabling them to be more precise, record clinical data, facilitate diagnosis and enable decision support systems. Medical devices can also interact among themselves and provide electronic data to health records, if interoperability is addressed.

Across all of these areas, it is essential to ensure that ethical concerns are properly addressed. Data protection in particular is critical to maintaining the privacy of sensitive health information.

TABLE 13: DIGITAL TECHNOLOGIES FOR HEALTH: ACTIONS AND INTERVENTIONS

At policy level
• Develop, as appropriate, national eHealth strategies and plans and legislation and data protection policies around issues such as data access, sharing, consent, security, privacy, interoperability and inclusivity, consistent with international human rights obligations. • Examine whether the conditions are appropriate for introducing digital health interventions in areas such as birth registration, commodity management, telemedicine, client communication, health worker decision support, digital tracking of clients' health status and digital provision of education and training. • Establish mechanisms to learn about new developments around ICT globally and identify gaps in existing efforts that could be addressed through new technologies.
At operational level
• When evidence demonstrates effectiveness, move digital health interventions from pilots to scale, including by integrating digital technologies into existing health systems' infrastructures and regulation. • As appropriate, conduct health technology assessments. • Accelerate efforts to implement e-Health information systems, including e-Health records.
By people and communities
• Utilize ICT to become informed consumers of health information. • Use new avenues enabled by technology to provide feedback on health services.

3.8 Systems for improving the quality of care

Systems at the local, sub-national and national levels to continuously assess and improve the quality of integrated health services

The recent *Lancet Global Health* Commission on High Quality Health Systems in the SDG Era highlighted that more deaths in low- and middle-income countries are now occurring as a result of poor quality care than due to a lack of access to care (*53*).

Quality care is safe, effective and people-centred. Such care needs to be timely, efficient, equitable and integrated. Quality care is essential for improving performance, maintaining trust, ensuring the sustainability of the health system and guaranteeing that all efforts and resources invested in facilitating access to and delivering care are translated into improving people's health. Systems at the local, sub-national and national levels should be equipped to continuously assess, assure, evaluate and improve the quality of primary care, as well as integrated health services overall, by tailoring interventions selected from a wide range of evidence-based quality improvement interventions to best suit their needs.

A range of approaches can be used, but the emphasis should be on developing a multimodal suite of interventions tailored to the local context, while simultaneously working to improve the broader health systems' environment and culture that supports the delivery of quality care. Therefore, this is not a prescriptive framework, but rather a guide developed to provide an orientation that can be adapted to help countries improve the overall quality of integrated health services. The 2018 joint publication of WHO, the Organisation for Economic Co-operation and Development (OECD) and the World Bank on delivering quality health services highlights the importance of developing a national quality strategy and/or policy and outlines seven categories of interventions *(54)*:

- changing clinical practice at the front line: the gap between what is known to be effective care and what is routinely performed by providers is often large and reducing it requires a combination of approaches, such as improving the skills, knowledge and attitudes of providers and supplying clinical decision support systems (for example, protocols, checklists);
- setting standards: using evidence to establish standards — whether for specific conditions or particular populations — can support the consistent delivery of services;
- engaging and empowering patients, families and communities: people and communities often know best the challenges they face in receiving quality care — whether as a result of uncoordinated services, poor clinical skills or the insufficient provision of information — so engaging them as partners in efforts to improve quality is critical;
- providing information and education for health workers, managers and policy-makers: at all levels of a health system, understanding current performance, trends over time and comparisons with others (benchmarks) are critical to improve quality of care;
- using continuous quality improvement programmes and methods: there are many frameworks for quality improvement, but they generally share a commitment to using data to inform activated learning mechanisms that feature cycles of action, assessment and improvement;
- establishing performance-based incentives (financial and non-financial): both financial (for example, bonuses for achieving quality benchmarks or penalties for errors or readmissions) and non-financial (for example, awards, recognition) incentives are used in performance-based financing schemes to encourage and motivate health providers to improve quality;

- adopting legislation and regulation: laws and regulations can address a range of factors that influence quality (for example, coverage and benefits, payment mechanisms, medicines and devices), as well as focusing on specific types of providers (for example, private providers).

The pivotal role of setting national directions on quality is further expanded upon in the WHO *Handbook for national quality policy and strategy*, also released in 2018 *(55)*. Other key resources include the WHO Technical Series on Safer Primary Care *(56)*.

In any approach to improving quality, it is important to recognize that a change management process is typically required. This necessitates setting a vision (and targets), building support for the changes, communicating clearly about them and tracking progress. A range of stakeholders may be involved in these efforts, including people and communities, service providers (public and private), professional bodies, nongovernmental and faith-based organizations, universities and health professional education and training institutions, external evaluation or licensing agencies, health technology assessment agencies, ministries of health and sub-national, facility and community quality teams.

TABLE 14: SYSTEMS FOR IMPROVING THE QUALITY OF CARE: ACTIONS AND INTERVENTIONS

At policy level
• Develop a national quality policy and/or strategy involving stakeholders in alignment with national health policy and planning processes. • Routinely measure and publicly report on the quality of integrated health services, including measures of patient experience. • Ensure that quality improvement efforts are adequately financed, sustained and scaled up. • Include principles of quality in the pre- and in-service training of health professionals, as well as in continuous professional development. • Routinely measure and publicly report on the quality of providers using internationally comparable measurements where feasible, and including patient assessments.
At operational level
• Develop a costed operational plan to support the execution of the national quality policy/strategy. • Institute mechanisms to enable individuals, families, and communities to provide feedback on quality (for example, patient complaint forms) and then incorporate the feedback in improvement efforts. • Develop and sustain governance and leadership for quality and safety at the local level, for example, district and primary care quality teams and focal points. • Develop systems to monitor adherence to standards of care. • Put in place an infrastructure for generating and sharing learning on quality integrated health services.
By people and communities
• Contribute to the development of national directions on quality, as well as their operationalization at the sub-national level. • Use reporting mechanisms and feedback loops to inform health professionals about clinical performance in order to facilitate improvement.

3.9 Primary health care-oriented research

Research and knowledge management, including dissemination of lessons learned, as well as the use of the knowledge to accelerate scale-up of successful strategies to strengthen PHC-oriented systems

Systems, policies, strategies and operational plans should be informed by the best available evidence of what works and how. Implementation and health systems' research is key to providing this information. This includes research on interventions that support all components of the PHC orientation, strategies to best engage people in their own care and in service design, self-management of common health problems, the substitution of professionals and the transfer of care responsibilities along integrated care pathways. It is not enough to simply conduct this research. It is crucial to ensure its dissemination to inform policy and decision-making. In particular, dissemination is undergoing a rapid transformation as new options are enabled by modern ICT, such as wikis and co-learning models that operate virtually. Sharing successful approaches and models is important, but sharing failures is also important so that others can learn from these.

Implementation research related to PHC is grappling with a number of key challenges, including:

- devising strategies to address population needs and policy priorities and for adopting efficient approaches to priority setting;
- determining optimal ways to engage multisectorally in improving PHC outcomes;
- identifying the best approaches for adequately responding to the challenges posed by multimorbidity and inappropriate polypharmacy, both in terms of their management and prevention);
- reinvigorating a focus on equity, including effectively addressing the urban–rural divide;
- assessing the impact of and the most effective modalities for private sector service delivery, including assessing the implications for equity;
- developing and supporting models of knowledge transfer to bridge the knowledge gap and promote knowledge uptake in implementation and PHC systems' research.

Relevant stakeholders that need to be involved include research funders (public and charities), universities and research centres, health technology assessment institutions, scientific societies, ministries of science and research, and other government decision-makers and health care professionals. To the maximum extent possible, external researchers should partner with local institutions and build capacity in these institutions so that they can lead research processes.

Additionally, it is important to engage people and communities in the research process to the maximum extent feasible to ensure an understanding of which problems require implementation research, an appropriate design of studies, followed by engaging with them in the dissemination of findings and, finally, translating these into policy change. *(57–60)*

TABLE 15: PRIMARY HEALTH CARE-ORIENTED RESEARCH: ACTIONS AND INTERVENTIONS

At policy level
• Increase targeted funding for PHC-oriented research capacity (such as within national research institutes or schools) and dedicated financing, including for complex systems' research through standard and specific calls for proposals. • Adopt efficient models of knowledge transfer, potentially as part of the specific remit of PHC research institutes. • Apply an equity lens to health systems policy research and evaluation. • Develop and implement approaches to the co-production of PHC-oriented research (including research questions, design, dissemination and use) with people and communities, as well as establishing the involvement of people and communities as a requisite for access to publicly-funded projects.
At operational level
• Support the development of PHC-oriented research networks. • Support implementation research to inform the scale-up of effective interventions and models. • Involve communities in developing a shared research agenda for public health.
By people and communities
• Advocate for the involvement of people and communities in research questions, study design and conduct and dissemination. • Participate when public and patient involvement is introduced (for example, through community advisory boards).

3.10 Monitoring and evaluation

Monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors

It is impossible to deliver PHC effectively and efficiently without accurate, up-to-date data about the health status of individuals and the population and the current state of the health system. An increasing number of countries have recognized this and committed to focusing on strengthening health information systems. The number of countries reporting having a dedicated national health information policy or strategy increased from under 20 in 2006 to more than 80 in 2015. Of note, this tally does not count those that have embedded their health information systems' strategies within a broader national health strategy or an eHealth strategy *(48)*.

The first step in strengthening health information systems is being clear on what data are needed, which is typically captured in results' frameworks of documents such as national health strategies or PHC strategies. Considerable progress has been made in reaching agreement on standard definitions of indicators that can be used to track progress on many aspects of PHC as reflected in documents such as the 2018 Global Reference List of 100 Core Health Indicators (plus health-related SDGs) (*61*). The PHCPI has also identified a set of indicators specifically focused on PHC (*21*). Some gaps still remain, particularly in areas beyond primary care where there is less consensus on indicators for the "empowered people and communities" and "multisectoral policy and action" components of PHC. However, the integrated nature of the SDGs has prompted more attention to these areas in joint efforts such as the Health Data Collaborative (*62*).

The most common challenges relate not to the selection of indicators, but rather to the systems that produce the data for these indicators. Data can come from a range of sources, particularly:

- routine facility reporting systems (sometimes known as health management information systems);
- health system resources, such as health facility assessments, health financing data, health workforce data, and logistics management information systems;
- population-level sources, particularly regular population-based surveys of population health and health risks, civil registration and vital statistics' systems and censuses;
- surveillance data that detect public health threats;
- evaluations of programme performance.

Routine facility reporting systems are the cornerstone of PHC monitoring as they provide real-time information about programme performance, which is essential for improving service delivery. The past decade has seen major investments in improving health management information systems, particularly through the expansion of real-time reporting systems (for example, the roll-out of DHIS2 [*52*]) and in using electronic health records systems.

A variety of approaches are used to gather data about health systems resources. Health facility assessments, such as the Service Availability and Readiness Assessment, the Service Delivery Indicators project, and Service Provision Assessment surveys (*63–65*), can capture information that is not routinely reported, such as availability of essential equipment, medicines, supplies and human resources, functionality of equipment, staff capacity, compliance with clinical guidelines, quality of care and client experience. National health accounts provide essential financial information to inform policy choices, budgetary planning, resource allocation and to monitor accountability, and these should be complemented by household expenditure surveys and reviews of national budgets.

Many countries lack reliable data on their health workforce and so a system of national health workforce accounts can progressively improve workforce data through the use of a set of core indicators and standardization of the health workforce information system. Logistics management information systems are critical for tracking the availability of medical products throughout the supply chain.

The process for producing periodic household surveys (such as demographic and health surveys or multi-indicator cluster surveys) has been refined based on several years of experience and runs smoothly in most countries. These surveys are critical for generating nationally representative figures about the health status of the population and coverage of key interventions. However, given the time and expense for their conduct, they can typically only be done every four or five years. Less progress has been seen on civil registration and vital statistics' systems, although recently the Global Financing Facility has stepped up investments in these.

Surveillance systems draw from both routine facility systems and event-based channels that tap into a wider range of sources, including community-based sources. Primary care facilities and their community linkages are critical parts of detection and early warning systems. Rapidly advancing technologies provide new opportunities for involving the public to improve monitoring and alert capacities.

While the first three sources of data listed above provide descriptive statistics on the current state of affairs and trends over time, evaluation is the best way to determine whether or not a particular programme or intervention is resulting in the intended outcomes. It is good practice to ensure that evaluation is designed and built into a programme at the outset, based on a clear hypothesis and theory of change, rather than a component tacked on at the end of the programme. Building in evaluation approaches from the beginning enables the findings to contribute to corrections during implementation, rather than simply passing judgement at the end, and a wide array of different evaluation methodologies have been developed to enable this.

Across all of these, the spread of innovations in ICT is opening up new possibilities, with mobile phones and tablets in particular facilitating the rapid collection and sharing of data, while blockchain technology is being actively explored in the context of areas such as supply chain management. These can also help address one of the persistent challenges in many countries: the extent to which all providers — including community health workers, those in the private sector and in more remote areas — are covered by data collection systems. Another key challenge with routine systems is data quality. A number of tools have been developed in recent years to assist with reviewing and improving quality (for example, by WHO and MEASURE Evaluation [*66*, *67*]), many of which build on advances in ICT.

With all these sources of data, it is important to recognize that sensitive data are being collected, which means that robust systems should be in place to ensure privacy and data protection. In this regard, new technologies are a double-edged sword as they simultaneously create new ways to store data securely and open up data systems to new forms of intrusion.

Having reliable data sources is necessary for improving programme performance, but it is not sufficient: the data must be put to use for identifying bottlenecks and making course corrections. There are technical dimensions to this challenge, such as data need to be made available in a timely manner and in easy-to-digest formats, a major element to ensure that the utilization of data is building a culture of regularly reviewing data and being used to inform decision-making. This is a

behavioural task that requires as much attention — including through training and incentives — as the technical challenge.

One way to do this is to create a regular moment when key stakeholders come together to examine data and make course corrections based on it. Many countries hold annual reviews of progress, occasionally in the form of a widely consultative national health assembly *(68)*. Midterm reviews of national strategies are another important moment to synthesize and analyse data and reflect on what the evidence is showing. Such reviews should be informed by a comprehensive analytical report that provides an in-depth analysis and synthesis of all relevant data. At health facility and sub-national levels, scorecards or dashboards including a limited set of key indicators with targets and "traffic lights" have a significant potential for improving data quality control and regular reviews of primary care performance. A number of resources (such as MEASURE Evaluation and WHO's curriculum on routine health information systems [*69*]) and tools (such as UNICEF's EQUIST [*70*]) have been developed to support countries in building capacity in collecting and using data. Finally, technology developments — "big data" — are creating new opportunities to synthesize large amounts of data, including from disparate datasets. This opens the door to identifying patterns across them and contributing to implementation research efforts (as described in Section 3.10).

The above discussion focuses on data within the health sector, but since multisectoral policy and action is a crucial component of PHC, a part of reviews of performance data should be drawn from other sectors, such as water and sanitation, education, the environment and agriculture. The specifics of these data will vary by country, depending on the most relevant social, economic, environmental and commercial determinants of health, but this will typically require building collaboration with relevant non-health ministries.

Last but not least, although monitoring and evaluation are often thought of as the domain of health systems and specifically ministries of health, people and communities can play important roles in generating information about their own health and about their experiences interacting with health systems. In high-income countries, innovations in ICT have enabled people to track their own health status and its key determinants (such as caloric intake or exercise levels) much more accurately than in previous generations and these are starting to spread globally, with new applications continually expanding how mobile phones and other technologies can be used to track different elements of a person's health. Mobile technology has also opened up new ways for people to report on the quality of the health care that they receive and on related matters such as governance issues. For example, UNICEF's U-Report system has facilitated millions of young people in more than 40 developing countries to directly engage on issues that are most important to them, including their experiences with health systems *(71)*.

TABLE 16: MONITORING AND EVALUATION: ACTIONS AND INTERVENTIONS

At policy level
• Ensure the availability of an updated national health information strategy. • Agree on key, nationally appropriate indicators to track progress on PHC. • Strengthen systems to collect data, including through routine systems, household surveys, facility surveys and evaluations. • Employ ICT to extend the reach of health management information systems, including to the private sector and remote areas. • Build a culture of reviewing data and using it to make decisions, including by conducting regular multi-stakeholder reviews.
At operational level
• Strengthen systems to collect and use data, particularly those gathered through routine systems. • Develop incentives (financial and non-financial) to promote improvements in data quality. • Supervise the system of data collection, using techniques such as a system of random assessments or lot quality assurance approaches. • Build capacity to process and use data at the sub-national level for local decision-making. • Use information from routine systems as a starting point for improving supportive supervision of frontline workers.
By people and communities
• Use new ICT to improve personal tracking of health. • Engage in efforts to improve the quality of health services by using reporting mechanisms to identify good and bad practices.

4. Contributions by international partners

As recognized in the commitments in the Declaration of Astana, the alignment of stakeholder support to national policies, strategies and plans across all sectors and under country leadership is essential to make sustainable PHC progress towards universal health coverage. International partners — including United Nations organizations, bilateral and multilateral donors, philanthropies and partnerships — support PHC in countries in a wide variety of ways at national, regional and global levels. This includes providing normative guidance, technical assistance, capacity building, financing, support for cross-border learning, development of tools, and knowledge generation and management. These efforts must be stepped up in order to accelerate progress.

In addition to continuing to support PHC in these ways, international partners have increasingly recognized that they can become more efficient and effective in the provision of their support by better coordinating their efforts guided by the direction of countries. Global partners must deliver PHC support through an integrated approach that maximizes on the diverse strengths and capacities of different stakeholders, while responding to country-identified priorities and needs. The alignment of donor and technical support to national health sector policies, strategies and plans, especially in countries that are largely dependent on external funding to make PHC a reality, is especially important to operationalize the PHC vision.

Over the past two decades, countries and the global development community have committed to principles of development effectiveness, including the "seven behaviours" for health development effectiveness and the principles that guide the UHC2030 Global Compact for progress towards universal health coverage. In addition, during the Fourth High-Level Forum on Aid Effectiveness in 2011, the following principles were agreed upon by more than 160 countries and 50 organizations in the Busan Partnership agreement, building on prior agreements on Aid Effectiveness in Rome (Italy), Paris (France) and Accra (Ghana): (1) inclusive development partnerships; (2) ownership of development priorities by developing countries; (3) focus on results; and (4) transparency and accountability to each other.

TABLE 17: PRINCIPLES OF DEVELOPMENT EFFECTIVENESS

Seven behaviours for health development effectiveness	Guiding principles of UHC2030 Global Compact
• Provide well-coordinated technical assistance • Support a single national health strategy • Record all funds for health in the national budget • Harmonize and align with national financial management systems • Harmonize and align with national procurement and supply systems • Use one information and accountability platform • Support south-to-south and triangular cooperation	• Leaving no one behind: a commitment to equity, non-discrimination and a rights-based approach • Transparency and accountability for results • Evidence-based national health strategies and leadership, with government stewardship to ensure availability, accessibility, acceptability and quality of service delivery • Making health systems everybody's business – with engagement of citizens, communities, civil society and the private sector • International cooperation based on mutual learning across countries, regardless of development status and progress in achieving and sustaining universal health coverage and development effectiveness principles

The International Health Partnership for Universal Health Coverage 2030 (UHC2030)

UHC2030 is the multi-stakeholder movement to accelerate progress towards UHC. Its diverse membership and constituencies includes countries, international organizations and global health initiatives, philanthropic foundations, civil society and the private sector.

UHC2030 seeks to contribute to stronger, more resilient health systems and the expansion of both coverage and financial protection. Its objectives and approach include enhancing commitment (political and financial) and accountability for UHC and promoting more coherent joint working by countries and all relevant health partners in response to countries' health systems and UHC needs.

Global Action Plan for Healthy Lives and Well-being for All

WHO, in partnership with 11 other United Nations organizations, is facilitating an initiative to improve the collaboration of global actors so as to leverage the reach, experience and expertise of the collective global health community to accelerate progress towards the health-related targets of the 2030 Agenda for Sustainable Development. The SDG Global Action Plan for healthy lives and well-being for all (SDG3+ GAP) brings together the commitment of the 12 United Nations organizations under a common approach founded upon four strategic commitments (*72*, *73*):

- engage: a commitment to work together with countries to identify priorities and plan and implement together;
- accelerate: a commitment to act together to support countries under specific accelerator themes, including gender equality and global public goods;
- align: a commitment to harmonize operational and financial strategies, policies and approaches;
- account: a commitment to review progress and learn together to enhance shared accountability.

Within SDG3+ GAP, PHC has been identified as the first of seven cross-cutting accelerator themes in which partner collaboration and joint action offer substantial opportunities to step up progress towards SDG3 and the health-related SDGs (*73*). The remaining six accelerator themes – sustainable financing for health, community and civil society engagement, determinants of health, innovative programming in fragile and vulnerable settings for disease outbreak responses, research and development, innovation and access, and data and digital health – link closely to the core strategic and operational levers under the umbrella of PHC and offer further opportunities for partners to join together in a collective PHC approach in countries.

In addition to these 12 United Nations organizations, global partners working on PHC were previously convened in an "Implementing Partners for PHC" group that also examined issues of coordination. In 2019, the group joined together with SDG3+ GAP partners in an agreement to better coordinate and collaborate around PHC implementation under the PHC accelerator. This broader collaboration may form part of a partner collaborative under the umbrella of UHC2030.

SDG3+ GAP Partners have agreed on several joint actions on primary health care (Table 18).

TABLE 18: GLOBAL ACTION PLAN FOR HEALTHY LIVES AND WELLBEING: AGREED JOINT ACTIONS ON PRIMARY HEALTH CARE

Country-level actions	Global/regional-level actions
Support countries through aligned, collective action in the following areas: • support assessment of PHC, aligning existing agency-level approaches and using a common approach to health systems assessment; • provide tailored and coordinated country support to strengthen health systems for PHC by generating evidence, country prioritization, planning and budgeting, mobilization of financing, and health workforce development to improve coverage and equity, including in fragile and vulnerable settings; and • provide assistance to identify who is being left behind and why and prioritize integration with other sectors to influence determinants of health and health outcomes.	Ensure more coherent, effective support to countries by aligning approaches and tools and promoting action on public goods in the following areas: • collaborate on the three components of PHC using existing mechanisms, including reframing financial support, where appropriate; • use existing global mechanisms to agree on a framework for the monitoring of PHC with improved metrics to be made available for adaptation and use by countries, including on financing; • refine and strengthen the capacity of partners to effectively engage, accelerate, align and account in order to advance PHC through their work at country level using common tools, instruments and approaches; and • develop, finalize and scale-up "leave no one behind tools" and approaches to promote common United Nations Country Team Guidance.

UNICEF and WHO, co-leaders of the PHC accelerator, will support the coordination function at country and global level. This coordination mechanism does not supersede or replace any ongoing health sector coordination arrangements that already exist in a given country.

Incremental change in PHC as a result of isolated actions and interventions along the levers included in this draft Operational Framework will not be sufficient to achieve UHC and the health-related SDGs. The two latter goals will require bold action based on political leadership with an explicit, strong and well-defined vision and the engagement of people, communities and other stakeholders, guided by evidence and a monitoring and evaluation framework relevant to PHC. Lessons from prior efforts to coordinate partners around national health policies, strategies and plans must be applied to these ongoing mechanisms if global partners are to be part of a successful PHC transformation in countries. In each country, strong governmental leadership and ongoing advocacy for the harmonization and alignment of global donors and technical partners involved in strengthening PHC are needed if we are to deliver on the vision of PHC and the commitments of the Declaration of Astana.

References

1. Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007.

2. Siddiqi S, Masud T, Nishtar S, Peters DH, Sabri B, Bile KM et al. Framework for assessing governance of the health system in developing countries: gateway to good governance. Health Policy. 2009;90(1):13–25.

3. The 8th Global Conference on Health Promotion, Helsinki, Finland, 10–14 June 2013: the Helsinki Statement on Health in All Policies. Geneva: World Health Organization; 2013.

4. Contributing to social and economic development: sustainable action across sectors to improve health and health equity. WHA67.12. Sixty-seventh World Health Assembly, May 2014.

5. Blas E, Roebbel N, Rajan D, Valentine N. Chapter 12: Intersectoral planning for health and health equity. In: Schmets G, Rajan D, Kadandale S, editors. Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016.

6. Adelaide Statement II: Outcome Statement from the 2017 International Conference Health in All Policies: Progressing the Sustainable Development Goals. Geneva: World Health Organization; 2017.

7. Progressing the Sustainable Development Goals through Health in All Policies: case studies from around the world. Government of South Australia and World Health Organization; 2017

8. Key learning on Health in All Policies implementation from around the world: information brochure. Geneva: World Health Organization; 2018.

9. Social determinants of health. Health and development governance: Health in All Policies. Geneva: World Health Organization (http://www.who.int/social_determinants/healthinallpolicies-hiap/en/, accessed 19 October 2018).

10. Xu K, Soucat A & Kutzin J et al. Public Spending on Health: A Closer Look at Global Trends. Geneva: World Health Organization; 2018.

11. Data from the Global Health Expenditure Database, http://apps.who.int/nha/database/Home/Index/en/. Accessed 8 July 2019

12. Sarrami-Foroushani et al. Implementing strategies in consumer and community engagement in health care: results of a large-scale, scoping meta-review. BMC Health Services Research 2014, 14:402.

13. WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017.

14. Primary Health Care Performance Initiative. Community engagement. https://improvingphc.org/improvement-strategies/population-health-management/community-engagement, accessed 8 July 2019.

15. Clarke D, Doerr S, Hunter M, Schmets G, Soucat A, Pavisa A. The private sector and universal health coverage. Bulletin of the World Health Organization 2019;97:434-435.

16. Integrated care models: an overview. Copenhagen: World Health Organization Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf With access on 17/9/2018, accessed 20 October 2018).

17. People-centred and integrated health services: an overview of the evidence. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/handle/10665/155004/WHO_HIS_SDS_2015.7_eng.pdf?sequence=1, accessed 20 October 2018).

18. Framework on integrated, people-centred health services: report by the Secretariat. Sixty-ninth World Health Assembly, agenda item 16.1. Geneva: World Health Organization; 2016 (http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf, accessed 20 October 2018).

19. Kruk ME, Porignon D, Rockers PC, Van Lerberghe W. The contribution of primary care to health and health systems in low-and middle-income countries: a critical review of major primary care initiatives. Social Science and Medicine. 2010;70(6):904–11.

20. Kane J, Landes M, Carroll C, Nolen A, Sodhi S. A systematic review of primary care models for non-communicable disease interventions in sub-Saharan Africa. BMC Family Practice. 2017;18:46. doi:10.1186/s12875-017-0613-5.

21. Primary Health Care Performance Initiative: indicators library (https://improvingphc.org/content/indicator-library, accessed 20 October 2018).

22. Lessons from transforming health services delivery: compendium of initiatives in the WHO European Region. Geneva: World Health Organization; 2016 (http://www.euro.who.int/en/health-topics/Health-systems/health-services-delivery/publications/2016/lessons-from-transforming-health-services-delivery-compendium-of-initiatives-in-the-who-european-region-2016, accessed 20 October 2018).

23. WHO and UNICEF. Technical Series on Primary Health Care. Primary health care: closing the gap between public health and primary care through integration. 2018 (https://www.who.int/docs/default-source/primary-health-care-conference/public-health.pdf, accessed 9 July 2019).

24. Dussault G, Kawar R, Castro Lopes S, Campbell J. Building the primary health care workforce of the 21st century. Background paper to the Global Conference on Primary Health Care: From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals. Geneva: World Health Organization; 2018.

25. Health workforce requirements for universal health coverage and the sustainable development goals. Human Resources for Health Observer Series No. 17. Geneva: World Health Organization; 2017 (http://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf?sequence=1, accessed 20 October 2018).

26. Global Strategy on Human Resources for Health: Workforce 2030. Geneva: World Health Organization; 2016 (http://www.who.int/hrh/resources/pub_globstrathrh-2030/en/, accessed 20 October 2018).

27. Day-Stirk F, Massoud R. Improving health worker productivity and performance in the context of universal health coverage: the roles of standards, quality improvement, and regulation. Technical Working Group (TWG) #7 (http://www.who.int/workforcealliance/media/news/2014/WG7_Productivityandperformance.pdf, accessed 20 October 2018).

28. Bouzid M and Hunter P. What is the impact of water, sanitation and hygiene in healthcare facilities on care seeking behaviour and patient satisfaction? A systematic review of evidence from low- and middle-income countries. 2018. BMJ Global Health. 3;3.

29. A study on the public health and socioeconomic impact of substandard and falsified medical products. Geneva: World Health Organization; 2017 (http://www.who.int/medicines/regulation/ssffc/publications/Layout-SEstudy-WEB.pdf, accessed 20 October 2018).

30. World Health Organization. Health technology assessment. (http://www.who.int/health-technology-assessment/en/, accessed 20 October 2018).

31. World Health Organization. Model list of essential medicines: 21st list. 2019 (https://apps.who.int/iris/handle/10665/325771, accessed 10 July 2019).

32. The World Bank Group. Climate-smart healthcare: Low-carbon and resilience strategies for the health sector. 2017 (https://openknowledge.worldbank.org/handle/10986/27809, accessed 10 July 2019).

33. Mackintosh M, Channon A, Karan A, Selvaraj S, Cavagnero E, Zhao H. What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. Lancet. 2016;388(10044):596–605.

34. Grépin K. Private sector an important but not dominant provider of key health services in low- and middle-income countries. Health Affairs (Millwood). 2016;35(7):1214–21.

35. Powell-Jackson T, Macleod D, Benova L, Lynch C, Campbell OM. The role of the private sector in the provision of antenatal care: a study of Demographic and Health Surveys from 46 low- and middle-income countries. Tropical Medicine and International Health. 2015;20(2):230–9.

36. Private sector accounts (http://www.privatesectorcounts.org/), accessed 20 October 2018).

37. McPake B, Hanson K. Managing the public–private mix to achieve universal health coverage. Lancet. 2016;388(10044):622–30.

38. Thomas C, Makinen M, Blanchet N, Krusell K, editors. Engaging the private sector in primary health care to achieve universal health coverage: advice from implementers, to implementers. Joint Learning Network for Universal Health Coverage Primary Health Care Technical Initiative; 2016.

39. Montagu D, Goodman C. Prohibit, constrain, encourage, or purchase: how should we engage with the private health-care sector? Lancet. 2016;388(10044):613-21.

40. SHOPS Plus. Assessment to action: a guide to conducting private health sector assessments (https://assessment-action.net/, accessed 20 October 2018).

41. Phalkey RK, Butsch C, Belesova K, Kroll M, Kraas F. From habits of attrition to modes of inclusion: enhancing the role of private practitioners in routine disease surveillance. BMC Health Services Research 2017;17:599.

42. Learning exchange on financing and payment models for primary health care: six lessons from JLN country implementation experience. Joint Learning Network for Universal Health Coverage and GIZ (http://www.jointlearningnetwork.org/PHC_learning_exchange, accessed 21 October 2018).

43. Langenbrunner JC, Cashin CS, O'Dougherty S, editors. Designing and implementing health care provider payment systems: how-to manuals. Washington (DC): World Bank; 2009.

44. Cashin C, Chi Y-L, Smith PC, Borowitz M, Thomson S. Paying for performance in health care: implications for health system performance and accountability. European Observatory on Health Systems and Policies Series. Maidenhead, United Kingdom: McGraw-Hill Education; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0020/271073/Paying-for-Performance-in-Health-Care.pdf, accessed 21 October 2018).

45. Joint Learning Network. Using Data Analytics to Monitor Health Provider Payment Systems. 2017 (http://www.jointlearningnetwork.org/resources/data-analytics-for-monitoring-provider-payment-toolkit, accessed 10 July 2019).

46. ICT facts and figures 2017 [and related downloads]. International Telecommunication Union (https://www.itu.int/en/ITU-D/Statistics/Pages/facts/default.aspx, accessed 21 October 2018).

47. World development report 2016: digital dividends. Washington (DC): World Bank; 2016 (http://www.worldbank.org/en/publication/wdr2016, accessed 21 October 2018).

48. Global diffusion of eHealth: Making universal health coverage achievable. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/handle/10665/252529/9789241511780-eng.pdf?sequence=1, accessed 21 October 2018).

49. National eHealth strategy toolkit. World Health Organization and International Telecommunication Union; 2012 (http://www.who.int/iris/handle/10665/75211, accessed 21 October 2018).

50. World Health Organization. Classification of digital health interventions v1.0: A shared language to describe the uses of digital technology for health. 2018 (https://www.who.int/reproductivehealth/publications/mhealth/classification-digital-health-interventions/en/, accessed 10 July 2019).

51. World Health Organization. WHO guideline: recommendations on digital interventions for health system strengthening. 2019

(https://www.who.int/reproductivehealth/publications/digital-interventions-health-system-strengthening/en/, accessed 10 July 2019).

52. DHIS2 (https://www.dhis2.org/, accessed 21 October 2018).

53. Kruk ME et al. for the Lancet Global Health Commission on High-Quality Health Systems in the SDG Era. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Global Health. 2018: doi:10.1016/S2214-109X(18)30386-3.

54. Delivering quality health services: a global imperative for universal health coverage. Geneva: World Health Organization, Organisation for Economic Co-operation and Development, and World Bank; 2018 (http://apps.who.int/iris/bitstream/handle/10665/272465/9789241513906-eng.pdf?ua=1, accessed 20 October 2018).

55. Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care. Geneva: World Health Organization; 2018.

56. Technical Series on Safer Primary Care. Geneva: World Health Organization; 2016 (http://www.who.int/patientsafety/topics/primary-care/technical_series/en/, accessed 20 October 2018).

57. Special Programme for Research and Training in Tropical Diseases: implementation research toolkit. Geneva: World Health Organisation (http://www.who.int/tdr/publications/topics/ir-toolkit/en/, accessed 21 October 2018).

58. Goodyear-Smith F, Mash R. How to do primary care research. CRC Press; 2018.

59. Awoonor-Williams JK, Appiah-Denkyira E. Bridging the intervention–implementation gap in primary health care delivery: the critical role of integrated implementation research. BMC Health Services Research. 2017;17(3):772.

60. Paina L, Ekirapa-Kiracho E, Ghaffar A, Bennett S, editors. Engaging stakeholders in implementation research: tools, approaches, and lessons learned from application. Health Research Policy and Systems; 2017.

61. Global Reference List of 100 Core Health Indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (http://www.who.int/healthinfo/indicators/2018/en/, accessed 21 October 2018).

62. Data for health and sustainable development. Health Data Collaborative (https://www.healthdatacollaborative.org/, accessed 21 October 2018).

63. Service Availability and Readiness Assessment (SARA) (https://www.who.int/healthinfo/systems/sara_introduction/en/, accessed 31 January 2020).

64. Service Delivery Indicators (https://datacatalog.worldbank.org/dataset/service-delivery-indicators, accessed 31 January 2020).

65. Service Provision Assessments (SPA) – The DHS Program (https://dhsprogram.com/What-We-Do/Survey-Types/SPA.cfm, accessed 31 January 2020).

66. Data Quality Review (DQR) Toolkit. Geneva: World Health Organization (http://www.who.int/healthinfo/tools_data_analysis/en/, accessed 21 October 2018).

67. Routine data quality assessment tool: user manual. MEASURE Evaluation; 2017 (https://www.measureevaluation.org/resources/publications/ms-17-117, accessed 21 October 2018).

68. The triangle that moves the mountain: nine years of Thailand's National Health Assembly. Geneva: World Health Organization; 2017.

69. RHIS curriculum. MEASURE Evaluation (https://www.measureevaluation.org/our-work/routine-health-information-systems/rhis-curriculum, accessed 21 October 2018).

70. EQUIST: equitable strategies to save lives. United Nations Children's Fund (http://www.equist.info/, accessed 21 October 2018).

71. U-Report (https://ureport.in/, accessed 21 October 2018).

72. World Health Organization. Global Action Plan for healthy lives and well-being for all. 2019 (https://www.who.int/sdg/global-action-plan, accessed 10 July 2019).

73. World Health Organization. Stronger collaboration, better health: global action plan for health lives and well-being for all. (https://www.who.int/publications-detail/stronger-collaboration-better-health-global-action-plan-for-healthy-lives-and-well-being-for-all, accessed 26 December 2019).