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The PHC approach: an introduction

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Key messages

■Primary health care (PHC) is the cornerstone of strong and resilient health systems. It shapes health systems to respond to people's needs and preferences; to offer good quality, affordable care close to communities; and to engage people in a holistic and proactive approach to health and wellbeing. PHC is key to accelerating progress towards universal health coverage (UHC) and enhances efficiency, health equity and resilience.

■There are overlapping definitions of PHC but at its heart it is about delivering integrated health services – with linked primary care and essential public health functions; individual and community engagement; and policy and action across sectors, working together to offer joined-up provision and a whole-society and whole-system approach.

■PHC-oriented models of care unite the person-centred orientation of primary care services and the population focus of essential public health functions, enabling the strategic and operational decisions that lead to high-quality, integrated care.

■Implementing the PHC approach is an investment in UHC, health security and better health and wellbeing. It improves access, utilization, participation and quality.

■Hospitals and specialist settings concentrate resources, specialized expertise, innovation and technology, and have a crucial role to play in a PHC-oriented system if and when they:

■leverage their resources to support high-quality primary care;

■refer back to comprehensive primary care; and

■engage and communicate regularly with primary care providers.

■Through "natural experiments", countries have generated important know ledge and best practices on "how" to strengthen the PHC approach and translate it into action. Policy-makers can draw on their evidence to:

■reassess and reorientate models of care;

■understand what works in different contexts and to manage confounders, bottlenecks and unforeseen consequences; and

■use the available strategic and operational PHC levers to support health systems transition towards PHC, and improve health system performance.

1.1 Primary health care

1.1.1 Definition, values and principles of PHC

PHC has been the focus of renewed global attention over the past few years for its central role in achieving "health and wellbeing for all" (SDG3) amid the wider global agenda for health, peace and prosperity outlined in the Sustainable Development Goals.

The PHC approach, by definition, enhances health equity and shapes health systems to be resilient, efficient and responsive to people's needs and demands (WHO & UNICEF, 2018). It integrates population and individual-level health interventions and shifts efforts from a reactive approach to illness to a more holistic and proactive approach to health and wellbeing. As such, PHC provides an essential foundation to effectively address population health needs and serves as a basis for all health system strengthening efforts. This Volume uses the definition of PHC as outlined in the 2018 Astana Declaration and its accompanying document, "A vision for primary health care in the 21st century" (WHO, 2018a; WHO & UNICEF, 2018) (Box 1.1).

Box 1.1 Primary health care

■*PHC is a whole-society approach to health that aims to maximize the level and equitable distribution of health and wellbeing by focusing on people's needs and preferences as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care.*

■*The PHC approach accelerates progress towards achieving universal health coverage (UHC) and health security. At the same time, it enables health systems to have all essential health services readily available, of high quality, accessible and affordable to communities, as close as possible to people's everyday environment.*

■*PHC combines multisectoral policy and action, community engagement and high-quality services. It integrates population and individual-level health interventions and shifts efforts from a reactive approach to illness to a more holistic and proactive approach to health and wellbeing.*

Sources: WHO, 2018a; WHO & UNICEF, 2018

Throughout the 45 years since the 1978 Declaration of Alma Ata, and through its affirmation in the Declaration of Astana, the concept of PHC has been repeatedly reinterpreted. Where linguistics and ideologies may have caused confusion and disagreement about the concept of PHC, its core values and principles have generally been a point of consensus (see Chapter 3). Central to the paradigm shift presented by the Declaration of Alma Ata and the renewed commitment expressed in the Declaration of Astana is a reframing of the "disease agenda" into a "health agenda" where health is understood as a state of physical, mental and social wellbeing rather than the mere absence of disease. Captured in the concept of PHC, this paradigm shift is an expression of the right to health –

the fundamental right of every individual to enjoy the highest attainable standard of physical and mental health.

The ***right to health*** is enshrined in various international human rights instruments, including the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights (UNGA, 1948; UN, 1967). It is further expressed in the principles that constitute the core of the PHC approach:

■**Universal access**: The right to health guarantees access to health services and care for everyone. PHC calls for, and enables, equitable access to health care and services for all individuals without discrimination regardless of age, gender, race, socioeconomic status, geographic location or their ability to pay.

■**Solidarity and equity**: The right to health calls for the reduction of social, economic and health disparities and the elimination of discriminatory practices. PHC purposefully addresses health inequities by prioritizing vulnerable and marginalized populations, attending first to those with the greatest need and ensuring that no one is left behind, including through multisectoral policy and action on adverse determinants of health.

■**Holistic approach**: The right to health emphasizes a comprehensive notion of health beyond the absence of disease. PHC recognizes and addresses the social, economic and environmental determinants that impact health, and integrates the full spectrum of care and services from health protection, promotion and education to disease prevention, treatment, rehabilitation and palliation for the overall wellbeing of individuals and communities.

■**Multisectoral involvement**: The right to health necessitates involvement and engagement beyond the health sector. PHC includes purposeful policy decisions to shape and enable health and wellbeing for individuals and communities beyond the delivery of primary care and essential public health services, including through the environment, transportation, labour and education sectors, among others.

■**Community participation to co-create health**: The right to health demands the participation of individuals and communities in the formulation, implementation and evaluation of health policies and programmes. PHC engages individuals and communities in decisions that affect their health and wellbeing, and includes active community participation in decision-making processes related to health as one of its core components.

■**Care which is of good quality and affordable**: The right to health requires that health services, including medicines, be available, accessible, acceptable and of good quality. PHC includes the delivery of affordable and high-quality integrated health services, including essential medicines, the use of appropriate health technologies and the participation of accountable and qualified health and care workers.

Through its three mutually dependant components (integration of primary care services and essential public health functions, multisectoral policy and action, and individual empowerment and community engagement) (see Fig. 1.1), PHC translates the right to health into concrete goals and highlights ways to achieve them. While health systems do not naturally evolve towards a PHC orientation, progress is entirely possible, as repeatedly demonstrated over the past decades in settings where political will and leadership have prioritized a PHC-oriented implementation.

1.1.2 Key concepts and terms

Advancing PHC through shared learning requires an a priori description of commonly used concepts and terms. In this section, key concepts and terms are described: PHC and primary care, generalism, essential public health functions, integrated health services, and models of care. These are central to the PHC approach and are consistently used across the chapters of this PHC Primer. These are also described and discussed in more detail in Part I of this Volume.

PHC and primary care

As described by the WHO, and for the purpose of this book, PHC and primary care refer to two related but distinct concepts (see also Chapter 3).

PHC is "a whole-of-society approach to health that aims equitably to maximize the level and distribution of health and wellbeing by focusing on people's needs and preferences (both as individuals and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment" (WHO & UNICEF, 2018). As an approach, it effectively organizes and strengthens national health systems to bring services for health and wellbeing closer to communities. As outlined in the Declaration of Astana (2018), it includes three inseparable and mutually influential components: multisectoral policy and action, empowered people and communities, and integrated health services with primary care and essential public health functions as their core (WHO & UNICEF, 2018). The PHC approach emphasizes action across sectors to address the social, economic, commercial and environmental determinants of health.

Primary care is the core of the service-fronting component of PHC and refers to essential health and social services that meet most of people's health needs, delivered close to home. In PHC-oriented systems, primary care enables first-contact access, continuity, comprehensiveness and coordination, also called "the 4Cs" (see Chapter 3). Together, essential public health functions and primary care balance individual and population-level interventions, and constitute the integrative component of all health services, including specialist, secondary and tertiary services, which are also planned and delivered according to PHC's key principles and support the delivery of high-quality primary care (WHO, 2018b).

Authors' Note: The term "PHC services" is often erroneously used to refer to primary care services. "PHC services" in this Volume refer to all interventions and actions involved in the implementation of a PHC-oriented approach, including many outside the health system to address the underlying reasons of people's wellbeing. Primary care services refer to health and social services delivered at the primary care level (see also Chapter 3 and Glossary).

Generalism

In PHC-oriented systems, primary care is expected to address most of people's health needs (WHO, 2018b) across the full spectrum of care and throughout the life course, through people-informed and person-centred care. To meet this ambitious goal, the delivery of primary care services needs to involve teams of health workers with an explicit interest and expertise in generalism.[1] Across professional groups, be they nurses, physicians, rehabilitation providers, dentists or others,

generalists are comfortable with diagnostic uncertainty, naturally adopt a “whole-person” approach, can integrate physical and social sciences, apply a wide breadth of expertise and expect to adapt their skills to meet clinical needs as they arise (Howe, 2012; Howe & Kidd, 2019). Generalists impart a degree of flexibility and adaptability to the delivery of health services that is particularly important to address complex chronic conditions at the individual level and to support the progressive expansion of available services in responsive health systems (see Chapter 8). This is because trained generalists can apply their clinical expertise to the growing range of long-term conditions, “manage risk safely, and share complex decisions with patients and carers, while adopting an integrated approach to their care” (Misky et al., 2022). As such, generalism is central to PHC.

In PHC-oriented health systems, generalist providers, especially those working in primary care, deliver a flexible and scalable number of services, playing a key role in imparting responsiveness to health systems. Long mistakenly associated with the absence of “special skills”, generalist medicine is increasingly recognized as requiring purposeful training. In many countries, highly trained generalist physicians responsible for high-quality primary care (and sometimes some secondary care) and trained according to the patient-centred clinical method are called family physicians. In PHC-oriented health systems, not all generalist providers are physicians and not all generalist physicians are family physicians but also include nurse practitioners, for example (Howe & Kidd, 2019). Yet the delivery of high-quality comprehensive primary care requires the involvement of family physicians in numbers and roles adapted to each specific environment. As outlined in Chapter 8, the key role of generalism, and specifically of family physicians in primary care and on primary care teams, has planning, resources and training implications.

Essential public health functions

Essential public health functions refer to a “fundamental and indispensable set of collective actions under the responsibility of the state which are needed to meet public health goals, including the attainment and maintenance of the highest level of population health possible within given resources” and “a means to plan, prioritize and provide key public health interventions for population health” (WHO, 2021).

The specific list of essential public health functions and the ways to operationalize them vary across countries and regions. As outlined in the WHO technical guidance document “A Vision for Primary Health Care in the 21st century”, and detailed in Chapter 5, efforts to integrate public health and primary care focus on the following functions: health protection, health promotion and disease prevention, surveillance and response, and emergency preparedness. Many essential public health functions correspond to levers of the WHO PHC Operational Framework, and are analysed in Part II of this Volume.

In the context of PHC, situating essential public health functions at the core of integrated health services conveys the central importance of population-based interventions in protecting and promoting health and in preventing illness, and calls for the inclusion of related interventions in packages of essential services. It also conveys the importance of giving first attention to addressing adverse determinants of health as their impact on health and illness outweighs that of individual curative services. Presenting primary care in tandem with essential public health functions underscores the complementarity and interdependence of population-based and individual-focused services. The essential contributions and high impact of population-based approaches to a PHC-oriented health care system are further outlined in Chapter 5.

Integrated health services

As proposed by the WHO's Framework on integrated people-centred health services, integrated health services refer to services that are "managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course" (WHO, 2016).

The distinction between "integrated" and "coordinated" care and services is not always clear and the terms are often used interchangeably. Integration involves purposeful technical and operational dimensions, as well as a relational dimension, and can occur through financial, administrative, organizational and clinical processes. The specific ways in which health services are ultimately integrated are reflected in models of care. In PHC-oriented health systems, integration is ultimately centred on people's needs.

In the context of PHC, services are integrated in different ways:

■Integrated population and individual-level services:

As mentioned above and discussed more in depth in chapter 5, in PHC-oriented systems population and individual-level services are integrated. They inform and mutually reinforce one another. This has implications for data collection, health workforce competency and capacity, funding and payment models as well as community engagement among others.

■Integrated services within and across levels of care:

In PHC, health services are integrated at the micro- and meso-levels among members of the primary care team, and possibly a network, "around" and centred on the person. When the needs of the patient exceed the capacity of the primary care team, the patient is easily and promptly referred to a specialist colleague or team at secondary and tertiary care levels, either in outpatient or inpatient facility settings. Effective integration requires all levels of care to be PHC-oriented. Transitions between providers across levels of care are best coordinated at primary care level with the integration of care supported by effective communication and the sharing of patient information through adequate and accountable referral and counter-referral mechanisms. Services can be integrated at the regional, sub-regional (such as districts or provinces) and/or local level (municipality, village or community).

■Integrated services across platforms and settings:

Integration is also important to ensure the safe and effective transition of care as individuals move from preventive to acute and chronic care, rehabilitation and palliation, and between facilities and care settings including home, primary care facilities, clinics, hospitals, hospices, nursing homes and long-term care facilities.

Models of care

A model of care refers to the way in which services are selected, organized and managed, and the implicit or explicit assumptions, values and goals that underpin that organization. In the context of PHC, models of care outline the configuration of service delivery that reflect PHC's principles and achieve its stated objectives.

There is no single PHC-aligned model of care as the various elements can be organized in several ways in order for service delivery to align with, reflect and enable the principles and goals of PHC. Models of care are shaped by values and principles, available resources, the types of services to be delivered and the target population (see Chapter 6).

In short, models of care outline "what" services (including the essential package of services) are provided and "for whom" (what population), "by whom" (health workforce), "where" (what platforms, facilities and settings) and "how". In PHC-oriented models of care, "how" refers specifically to strategies, processes and tools that lead to the desired outcomes such as equity, accessibility, quality, responsiveness and improved health outcomes.

In health systems not purposefully aligned with PHC, the dominant "default" model of care has traditionally been organized around hospitals and physician specialists. The implicit focus and priority of this model is the intensive use of technology and specialized expertise to cure disease. In some settings, a separate model exists for the delivery of health promotion and disease prevention services at the population level,

often with a primary and narrow focus on traditional hygiene and water sanitation measures, as well as addressing maternal and newborn health needs. Commonly, these services are not integrated with comprehensive individual care and are significantly under-resourced. As further elaborated in Chapter 6, in order to reap the full benefits of PHC, models of care need to steer away from an inefficient and inequitable "default" organization of health systems and enable integrated service delivery combined with community engagement and multisectoral action.

1.1.3 The three components of PHC

In this Volume, we use the PHC approach as defined in the Declaration of Astana and its accompanying vision document (WHO, 2018a; WHO & UNICEF, 2018), which incorporates the three inter-related and synergistic core components of PHC:

1. primary care and essential public health functions as the core of integrated health services with the aim to meet people's health needs throughout their lives;

2. addressing the broader determinants of health through multisectoral policy and action; and

3. empowering individuals, families and communities to take charge of their own health.

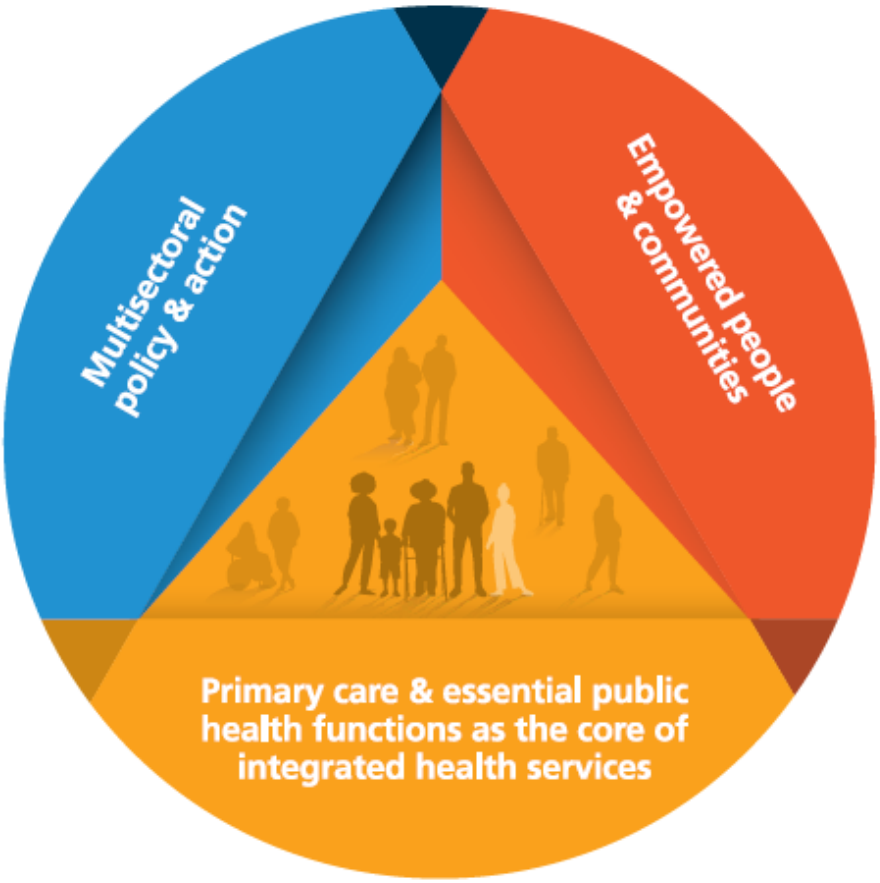
While the PHC approach as a concept is inherently complex, its interpretation and implementation commonly focus on only one of its three components – primary care services and essential public health functions as the core of integrated health care delivery – with or without very limited consideration of the other two (see Chapter 3).

Building on the depiction of PHC presented in the Declaration of Astana, a representation of the three components of PHC as a triangular pyramid is proposed in which integrated health services, the yellow plane of the pyramid, are depicted as the front-facing component and primary focus of attention in efforts to develop PHC-oriented health systems. This is because most activities and interventions required to implement PHC-oriented health systems take place through integrated health services and many of the demands and expectations of people with regards to their right to health are expressed through them (Fig. 1.1). The red and blue components, multisectoral actions

and community engagement, cannot be separated from integrated health services. They shape and are shaped by them and as such are inherent to a comprehensive implementation of the PHC approach through and across the whole of society.

The triangular pyramid conveys the interrelatedness of the three components of PHC and illustrates that any PHC-related action can be primarily focused on one of the components but will inevitably be connected to and involve the other two. At the intersection of the three components, at the centre of the pyramid, are people and their needs, be they individuals, families, communities or whole populations, who are the focus of the PHC approach and whose needs are addressed through all three components.

Fig. 1.1 The PHC approach as a triangular pyramid



Source: Authors, adapted from WHO & UNICEF, 2020

In PHC-oriented health systems, primary care services and essential public health functions constitute the core and foundation of all health services. As a whole-society approach, PHC informs how all actors, institutions and levels of the health system and beyond enable and support this foundational core of high-quality primary care and essential public health functions. Those not directly involved in the delivery of services nonetheless have a critical role in ensuring that all services, especially those in primary care and public health, are planned and organized according to a PHC-orientation of the whole system. In practice, this might mean, for example, allocating public spending to care delivery closer to communities, making decisions that optimize the delivery of integrated and person-centred care at facility level and in the community, including at home, and

establishing processes that ensure timely and integrated specialist care through effective referral and counter-referral to primary care.

Hospitals, as settings with concentrated resources, specialized expertise, hubs of innovation and technology, and as prime teaching environments, have a crucial role to play in a PHC-oriented system. They can leverage their resources to support high-quality primary care by enabling prompt access to secondary and tertiary care and to hospital- bound technology when needed, by ensuring referral back to comprehensive primary care particularly for ambulatory care-sensitive care conditions, and by engaging and communicating regularly with primary care providers to plan and deliver integrated and comprehensive care for the population. In high-performing health systems, hospitals and primary care providers work in tandem and their relationship is primarily informed by the needs of the people they serve.

Over the last decades, a large share of investment in health has been directed towards disease-based programmes (see Chapter 2) (De Maeseneer et al., 2008). Their importance has been supported by some evidence showing that the provision of disease-specific care results in better outcomes than primary care services for individuals affected by the disease of interest, a phenomenon called the primary care paradox (Homa et al., 2015) (Box 1.2).

Box 1.2 Disease-based (vertical) programmes and the primary care paradox

In many settings, especially in low- and middle-income settings, services are organized (and often funded) around body systems or functions (cardiovascular diseases, mental illness, renal diseases, etc.), specific diseases (HIV, TB, diabetes) or subpopulations (maternal health, paediatrics, etc.). While health systems anchored in robust high-quality primary care are clearly linked to better outcomes, equity and value at the population level (De Maeseneer et al., 2008), some evidence suggests that individual outcomes are sometimes better when services are delivered through disease-specific care and vertically organized programmes compared to comprehensive primary care. This phenomenon is referred to as the primary care paradox (Homa et al., 2015; Bitton, 2018).

A number of confounding factors likely contribute to this discrepancy. First, the clinical outcomes prioritized by vertical programmes are typically fewer and focused (but limited) and therefore easier to measure. Conversely, in a highly heterogenous population with multiple health issues, clinical outcomes are much more difficult to outline and measure both punctually and over time (Stange & Ferrer, 2009). Secondly, in part because of the appeal of their clearly measurable outcomes, vertical programmes often benefit from a disproportionate amount of resources compared to comprehensive (routine) primary care. These resources, in the form of medicines, equipment, facilities and human resources, can translate into timely and effective services, including the prompt transition of patients to other levels of care as needed, at least for the conditions of focus. Thirdly, health workers in vertical programmes can achieve higher levels of expertise faster as they often focus on a limited range of clinical problems and presentations and may benefit from a number of advantages such as better wages, recognition and focused continuing professional development. In contrast, health workers in primary care settings are expected to address the most common health issues, often in their undifferentiated state, and often work in less well resourced conditions, for lower wages, with limited support and often without adequate training. Together, these factors likely contribute to the gap in outcomes between vertical programmes and comprehensive care in some studies (Homa et al., 2015).

That is not to say that disease-focused integration is never indicated. In some cases, the complexity of needs, the concentration of the expertise required to address them and/or the frequency of

encounters call for vertical integration – that is, the seamless planning, funding, administration and delivery of services along the different stages of the patient pathway for a given condition or related group of conditions. This may be the case, for example, for some dialysis patients, people with severe chronic and treatment-resistant mental illness or complex cancer patients during active treatment for whom care is best provided by teams with the expertise to address complex care needs likely to exceed the skills of most primary care teams. Nonetheless, in most cases, individuals and populations do better overall when their care, including their preventive, acute and chronic care, is integrated and anchored in a continuous relationship with a primary care provider (or team) (Grunfeld, 2005).

Lastly, this paradox points to the fact that improved clinical outcomes at the population level and across all health needs can coexist with poorer clinical outcomes at the individual level. In a PHC approach, the delivery of comprehensive, person-centred (and not disease-focused) services seeks to bridge that gap.

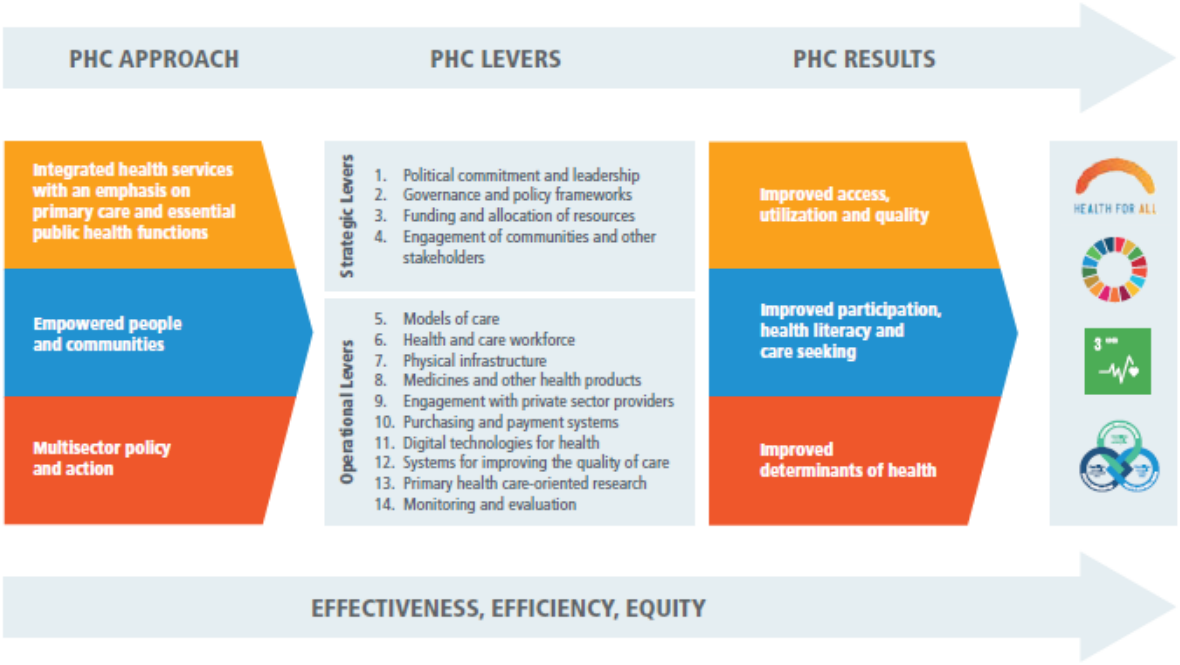
1.1.4 The PHC Operational Framework

Efforts to strengthen PHC can be analysed using the PHC Operational Framework with particular attention paid to how these levers can be implemented to align with the PHC approach – and ultimately impact achieving UHC and other health-related SDGs (see Box 1.1). The Operational Framework was developed at the request of Member States to translate the commitments of the Declaration of Astana into concrete policy and action and to accelerate countries' progress towards strengthening PHC-oriented systems (Fig. 1.2) (WHO & UNICEF, 2020; WHO, 2018a). The Framework proposes strategic and operational levers to guide transformational action and enable effective implementation across the three components of PHC. At the strategic level, PHC requires political commitment and leadership, legal frameworks and governance, funding and allocation of resources, and engagement of individuals, communities and stakeholders from all sectors.

At the operational level, PHC requires actions and interventions in key areas of integrated, people-centred models of care; engagement with private sector providers, workforce, physical infrastructure and appropriate medicines, products and technologies; digital technologies; purchasing and payment systems; systems for improving quality of care; and PHC-oriented research; as well as monitoring and evaluation. These levers are interdependent and mutually reinforcing/impact and enable one another.

PHC orientation is determined by the specific way in which each lever is implemented and by the interaction between the strategic and the operational levers, i.e. whether there is a clear and explicit political commitment and enabling policy framework, or which models of care are prioritized by governance actors and other stakeholders, and which workforce is cultivated, with which competencies and for which roles. The fourteen strategic and operational levers were derived from and complement the six health system building blocks proposed by WHO in 2007 (financing, governance, workforce, medicines and medical products, service delivery and information systems) (WHO, 2007).

Fig. 1.2 The PHC Operational Framework



Source: WHO & UNICEF, 2022

The PHC Operational Framework is reflected in the organization of this Volume and the operational levers provide the lens through which evidence on efforts to strengthen PHC is presented.

Each of the chapters in Part II of this book presents evidence on "how" a specific operational lever[2] can be used to orient a health system towards PHC in various contexts, with an analysis of the current evidence on implementation – what has worked well and what has worked less well (see Section 1.2). The strategic levers are allocated in the chapters on governance and financing (Chapters 7 and 9).

1.2 The Primary Health Care Primer

1.2.1 The aims of this Volume

Throughout the 45 years since the Declaration of Alma Ata (1978), implementation of PHC has evolved and resulted in substantial progress. Efforts by many countries to implement PHC-oriented health systems have produced diverse strategies to bring it to life. While PHC has been the subject of extensive analyses, treatises and reports, a textbook that summarizes the latest evidence on PHC implementation strategies and their impact on health systems performance is missing (Greenhalgh, 2013; Murray & Clendon, 2014; WHO & UNICEF, 2022; WHO Regional Office for Europe, 2022).

This textbook aims to support implementation of the PHC approach by presenting evidence on "how" countries have been using the various levers of the PHC Operational Framework to maximize the impact of PHC (WHO & UNICEF, 2020).

It complements existing publications with a more comprehensive and timely examination of the full breadth of actions taken to shift from health systems characterized by fragmented, often market-driven, hospital-centric and/or disease-focused approaches, to systems that deliver the full spectrum of people-centred, integrated, equitable and affordable health care and services, in a manner that expresses the values and principles of the Declarations of Alma-Ata and Astana.

To achieve its goal, this Volume seeks to:

■Cultivate a common understanding of PHC and of the specific role of primary care and essential public health functions at the core of integrated health services (Chapters 3 and 5).

■Analyse the trajectory of PHC since the Declaration of Alma-Ata, lay out its pivotal role in health systems of the 21st century and summarize the contemporary theoretical and political rationale for PHC (Chapters 2 and 4).

■Describe how models of care have been reoriented towards a PHC approach (Chapter 6).

■Elaborate on strategies and actions within each of the PHC Operational Framework levers that can support health systems transition towards PHC and showcase the diversity of approaches to implementing the PHC approach in different contexts (Part II chapters).

■Provide an analysis of the role and influence of contextual factors and confounders on the success, failure and/or unforeseen consequences of PHC implementation, and review how various PHC levers work (or do not work) to achieve UHC and in which circumstances (Parts II and III chapters).

■Emphasize the potential of PHC to achieve health system objectives and improve health system performance (Part III chapters).

■Through a critical analysis of the policies and actions to strengthen PHC, identify common enablers and barriers to advance PHC (Chapter 17).

1.2.2 Synthesis of empirical insights and country experiences

Narrative reviews conducted through the PHC lens

Teams of authors were selected for each chapter with attention to demonstrated content expertise and diverse geographic representation. Author teams were asked to undertake a narrative review of scientific and grey literature on their chapter's specific topic, and to summarize and analyse key findings, trends and knowledge gaps. A narrative review was chosen as it is a common method for rapidly collecting evidence and understanding complex topics and common issues, and has the potential to provide more in-depth information on specific topics than systematic reviews (Pautasso, 2019).

The narrative reviews were guided by two foundational questions:

■In a society committed to PHC, how can each of the operational levers be implemented to enable the delivery of integrated health services with primary care and essential public health functions at the core?

■How can engaged individuals and communities and multisectoral policy and actions purposefully shape service delivery to reflect and fulfill the principles of PHC?

Using these two foundational questions as a starting point, and based on their expertise, previous work and preliminary literature search, each author team refined its review, outlining specific research questions, selecting initial search terms, refining their literature search strategy, and outlining their own inclusion criteria regarding publication dates, language, type of studies, etc.

The search strategies were iteratively developed and refined following extensive scoping and piloting of search terms. For some chapters, authors encountered particular challenges in constructing a search strategy that offered sufficient sensitivity and specificity across the broad remit of the topic. The search strategy, the defined MeSH terms and search strings were discussed and validated by co-authors and editors in regular meetings.

Author teams searched the most widely used literature databases, such as Embase, Medline in Ovid, Cochrane CENTRAL, Web of Science Core Collection, CINAHL EBSCOhost, Scopus, Global Health, Google Scholar and others. In addition, the chapters draw on unstructured searches of grey literature sources such as policy documents, project reports and relevant websites; snowball sampling conducted via hand searching reference lists of key papers and other resources; and previous work and publications known to the authors. Some author teams also sent out a call to expert networks requesting literature.

The evidence reviews undertaken for this Volume reflect its primary focus on the integrated services component of PHC. Much of the literature presented pertains to the implementation of primary care services and essential public health functions, with particular attention paid to the ways in which multisectoral policy and action, and empowered people and communities, interact with integrated health services to shape and be shaped by them.

Country illustrations

In addition, each chapter team analysed selected country- and setting-specific cases and exemplars to identify and describe the contextual drivers, enablers and barriers that determine if and how their particular topic area impacts PHC implementation.

The country illustrations were selected from different sources. The most important ones are listed in Box 1.3 The selection of country illustrations was guided by the following criteria:

■policy changes that support pathways towards PHC orientation;

■policy changes that exemplify the topics identified in the evidence review;

■interventions and strategies that enhance PHC-orientation of health systems;

■policy changes that are transferable and/or provide lessons for different national or regional contexts; and

■evidence on impact.

Box 1.3 Sources for country illustrations

■*WHO PHC Country Case Study Compendium (a catalogue of existing case studies developed by WHO and partners with the aim to improve dissemination and use of case studies and reduce duplicate requests)*

■*PATH primary health care case studies*

■*PHC country vignette series developed by the WHO European Centre for Primary Health Care that highlights the transformation of primary health care during the COVID-19 pandemic*

■*Exemplars in Global Health on PHC*

■*Case Studies from the PRIMASYS initiative of the Alliance for Health Policy and Systems Research*

■*Country case studies and promising practices of the Primary Health Care Performance Initiative (PHCPI)*

■*Cases and country profiles of the Social Innovation in Health Initiative (SIHI)*

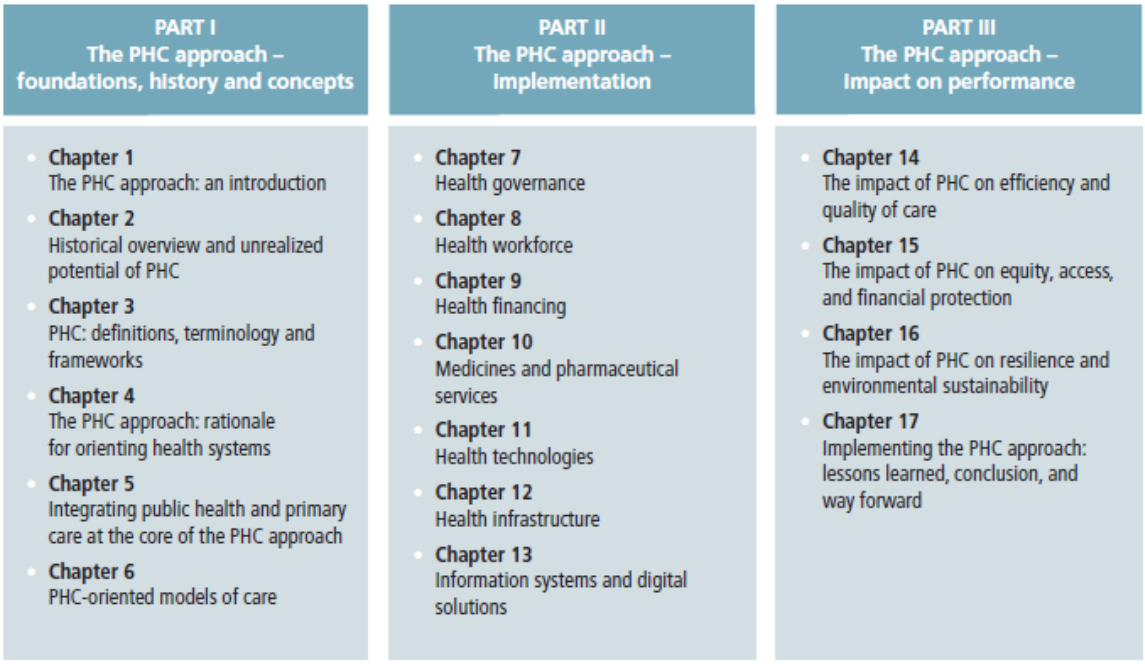
1.2.3 Structure of the book

This Volume is divided into three parts (see Fig. 1.3). Part I includes six chapters and provides an in-depth introduction to PHC. It lays out the historical background (Chapter 2), definitions and conceptual frameworks (Chapter 3) and the rationale (Chapter 4) of the PHC approach. Part I also describes the integration of primary care and essential public health functions, which is at the core of the PHC approach (Chapter 5) and lays out fundamental changes related to models of care congruent with a PHC approach (Chapter 6).

The second part (Part II) of the book consists of seven chapters, each summarizing evidence on how a given PHC lever has been implemented to align with the PHC approach. The chapters highlight knowledge gaps, focus on implementation lessons and point to implications for practice through in-depth country illustrations (see Fig. 1.3). In Part II a fictional story of a family (the Maluna family) illustrates how PHC unfolds in practice. At the beginning of each chapter readers will meet the different members of the Maluna family. Their stories illustrate how PHC-oriented interventions within each operational lever can impact the family's life and accelerate progress towards UHC.

The last part (Part III) consists of three chapters that examine the impact of PHC on key dimensions of health system performance, namely quality and efficiency (Chapter 14), equity, access and financial protection (Chapter 15), and resilience and environmental sustainability (Chapter 16). The concluding chapter (Chapter 17) reviews some of the key evidence presented in the book and summarizes salient implementation lessons for policy-makers.

Fig. 1.3 Structure of the PHC Primer (Volume I)



Source: Authors

This Volume leads the reader through an in-depth exploration of PHC. An initial review of the PHC approach and of what it entails for policy and practice is followed by an analysis of the operational evidence of policy and practice, and eventually leads to consideration of the impact of implementing the PHC approach on desired health system goals.

All chapters are organized into the same four sections. Section 1 is an introduction to the chapter topic and to the structure used to organize the content. For example, the financing chapter (Chapter 9) is framed around the well established financing functions of revenue raising, pooling and purchasing, while the chapter on medicines and pharmaceutical services (Chapter 10) is anchored around key selected issues that emerged from the review of the evidence related to the vast topic of medicines in PHC today. Section 2 summarizes and presents the results of the narrative reviews. Section 3 describes how countries have implemented the interventions presented in Section 2, with a particular focus on the reform implementation and outcomes. Section 4 summarizes the chapter's main messages, lessons learned and implementation challenges.

The content of this Volume provides a timely reminder not only of the vital importance of PHC in achieving health and wellbeing for all, of the wealth of knowledge and experience collected over the past decades, and of the remarkable progress achieved, but also of the persistent and emerging needs for greater efforts to radically reorient health systems towards the PHC approach.

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PHC GLOBAL REPORT
VOLUME 1

Implementing the Primary Health Care Approach: a Primer

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