



# Comment le contexte international influe-t-il sur la décision en santé ?

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Lausanne - 04 juin 2026





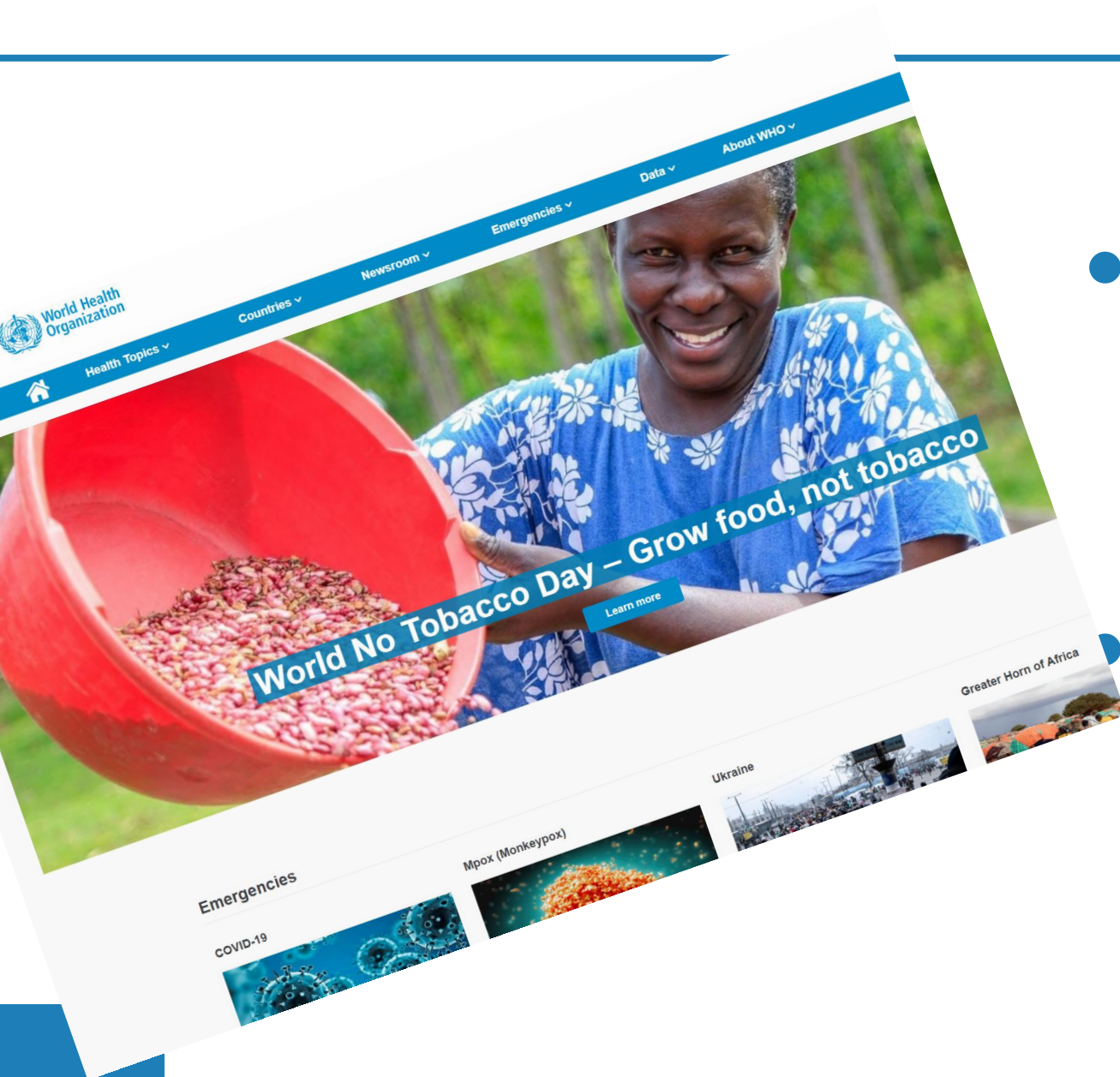
# Economie politique de la santé [1/2]

- Depuis toujours (Chine et Grèce anciennes, Europe médiévale, Moyen Orient,...), il est reconnu que la santé est influencée par des facteurs économiques, sociaux, géographiques,...
- En Europe, au moment de la révolution industrielle, les migrations, la mortalité et la détresse des masses ouvrières ont généré de nouvelles idées relatives aux liens entre travail, conditions sociales, politiques et santé
- En Europe de l'Ouest et centrale, en Amérique latine, en Afrique, en Asie ces idées se sont progressivement développées entre les 19<sup>ème</sup> et le 21<sup>ème</sup> siècles

# Economie politique de la santé [2/2]

- L'économie politique de la santé s'est élargie à d'autres considérations en lien avec le pouvoir : race/ethnicité, le genre, l'oppression (néo-) coloniale, la coopération au développement, le commerce, la gouvernance, les droits de l'homme (dont la santé fait partie), les acteurs de la santé,...
- Cette vision impose une lecture systémique de la santé, de ses déterminants et de la manière de répondre aux besoins et attentes des populations.
- Ces considérations sont universelles – même si elles sont battues en brèche dans certains pays - et s'articulent dans les pays au sein d'une vision politique et/ou des politiques de santé mises en œuvre.

# Création de l'OMS



- Coopération internationale et contrôle des maladies dès le milieu du 19ème siècle (1ère conférence sanitaire internationale à Paris en 1851)
- Création de l'Organisation des Nations Unies en 1945

# Création de l'OMS

- Constitution de l'Organisation Mondiale de la Santé en 1948



# Objectif de l'OMS

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**L'OMS s'est fixé comme but :**

**“ d’amener tous les peuples au niveau de santé le plus élevé possible “**

(Article 1, Chapitre I, Constitution de l'OMS)

# Définition de "Santé"

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La Constitution de l'OMS définit la santé comme suit:

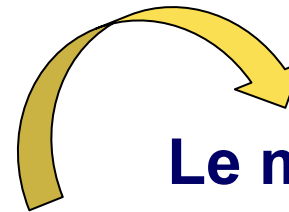
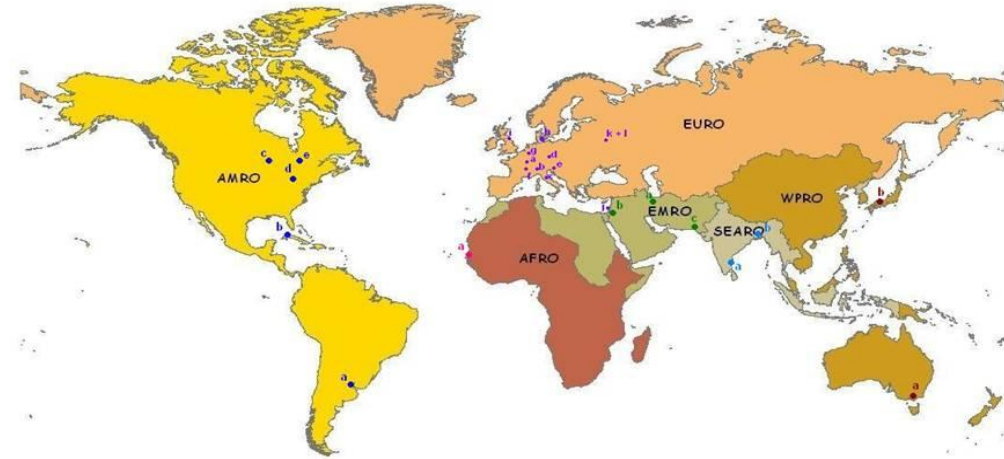
« La santé est un état de complet bien-être physique, mental et social, et ne consiste pas seulement en une absence de maladie ou d'infirmité »

(extrait de la Constitution de l'OMS)

# Structure de l'OMS (9000 staffs)

NB : en nette diminution depuis 18 mois

- Le siège est à Genève
- 6 bureaux régionaux (Copenhague, Washington DC, New Delhi, Manilla, Brazzaville, Cairo)
- 194 Etats membres et 151 bureaux dans les pays, territoires et zones qui travaillent étroitement avec les acteurs de la santé sur le terrain



**Le mandat officiel de l'OMS est d'être le premier conseiller du ministère de la Santé et du Gouvernement en matière de santé**

# Gouvernance de l'OMS

- **Assemblée mondiale de la santé:** C'est l'organe décisionnel suprême de l'OMS. Sa principale fonction est de déterminer la politique de l'Organisation.

UN état = UNE voix

- **Conseil exécutif:** Facilite le travail de l'Assemblée Mondiale
- **Le secrétariat de l'OMS:** le Directeur Général, et environ 6500 personnes travaillant au siège à Genève, dans les six bureaux régionaux et dans les bureaux de pays, territoires et zones.

# Les trois dimensions du travail de l'OMS

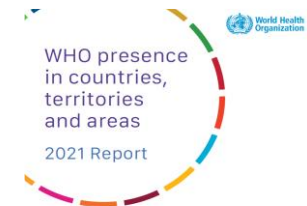
## ***La première dimension est globale:***

- Au niveau global l'OMS élabore les normes et standards internationaux
- L'Assemblée Mondiale de la Santé adopte des résolutions mondiales dont l'application est laissée à l'appréciation des Etats Membres et
- l'OMS s'engage avec d'autres partenaires internationaux (approche multisectorielle... exemple : quadripartite OneHealth)



## ***La deuxième dimension est l'appui aux pays:***

- Conseiller les gouvernements en matière de politique de santé et de mise en œuvre des normes et standards internationaux en matière de santé et lutte contre la maladie.
- En cas d'épidémies et dans les situations d'urgence humanitaire, l'OMS coordonne la coopération internationale en santé



## ***La troisième dimension est la coopération entre les pays:***

- L'OMS facilite la coopération entre ses régions et favorise la coopération sud-sud

# Latest Resolutions and Decisions on PHC and UHC from WHO Regional Committee Meetings



## AFRO :

- “PEN-Plus – A regional strategy to address severe noncommunicable diseases at first-level referral health facilities” RES (2022)
- Updated regional strategy for the management of environmental determinants of human health in the African Region 2022–2032 RES (2022)
- Regional strategy for health security and emergencies, 2022–2030 RES (2022)

## AMRO/PAHO:

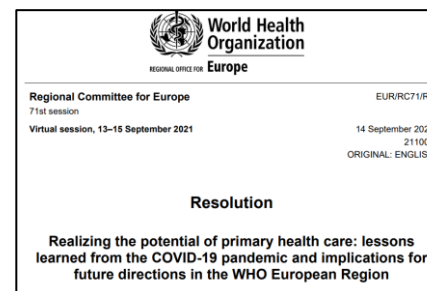
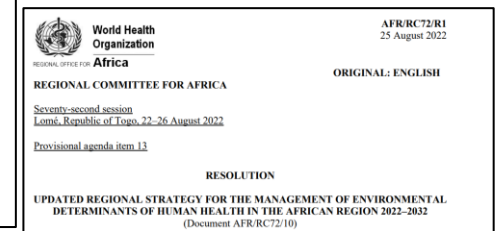
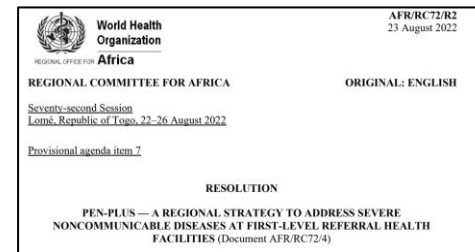
- Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains (2021)
- Policy to strengthen National Regulatory Systems for Medicines and Other Health Technologies (2022)
- Policy on Integrated care for improved Health Outcomes (2022)

## EMRO

- Building resilient health systems to advance universal health coverage and ensure health security in the Eastern Mediterranean Region (10-13 Oct. 2022)

## EURO:

- Realizing the potential of PHC: lessons learned from the COVID-19 pandemic and implications for future directions in the WHO European Region - RES (2021)
- Primary health care: making our commitments happen: realizing the potential of primary health care: lessons learned from the COVID-19 pandemic and implications for future directions in the WHO European Region (2022)



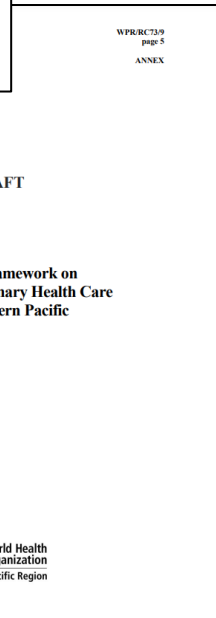
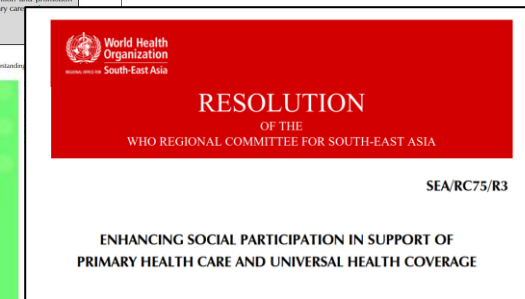
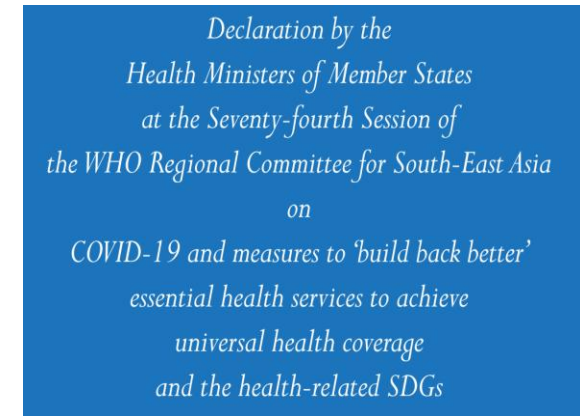
# Latest Resolutions and Decisions on PHC and UHC from WHO Regional Committee Meetings

## SEARO

- Declaration by the Health Ministries on COVID-19 and Measures to “Build back better” essential health services to achieve UHC and the health-related SDGs (2021)
- South-East Asia Regional Strategy for Primary Health Care: 2022-2030 (2021)
- Addressing mental health through primary care and community engagement in the WHO South-East Asia Region (2022) – RES “PARO declaration by the health ministers of Member States at the 75th session of the WHO Regional Committee for South-East Asia on universal access to people-centred mental health care and services”
- Achieving UHC, SDGs and health security through stronger and more comprehensive PHC (2022) – RES “Enhancing social participation in support of PHC and UHC”

## WPRO

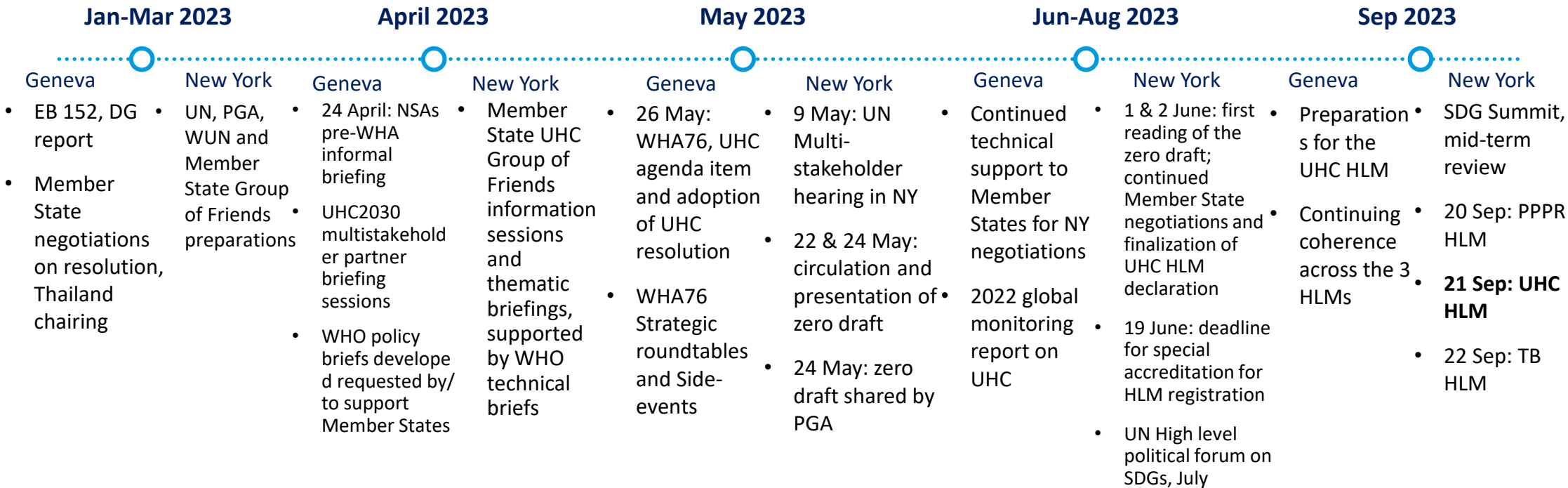
- High-level panel discussion on PHC Western Pacific RC Meeting (Oct. 2021)
- Regional Framework on the Future of Primary Health Care in the Western Pacific (WPR/RC73/9, Manila, The Philippines, 24-28 October 2022)



# UHC global roadmap to HLM 2023: Key Milestones

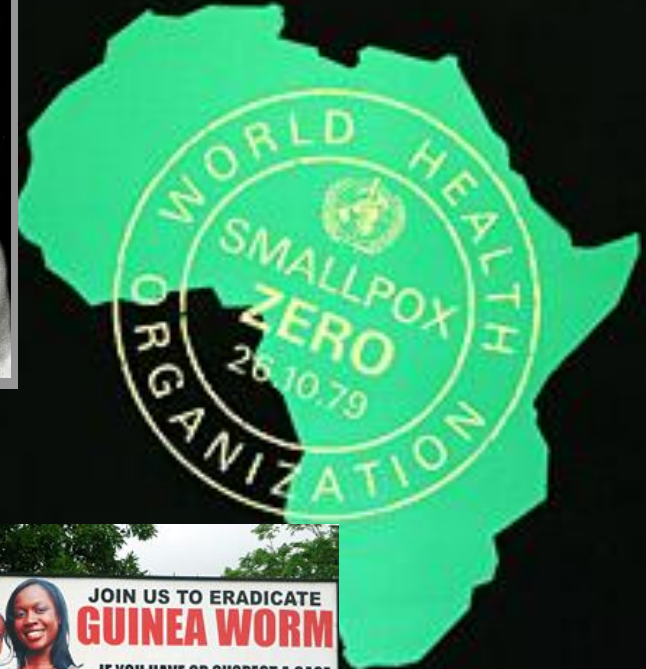
Ongoing Member State leadership towards a concise, action-oriented political declaration for the progressive realization of UHC and Health for All.

Supported by:



# Etapes importantes

- Le système de classification des maladies est systématisé en 1948 (ICD-11, actuellement)
- Lancement du programme d'éradication de la malaria en 1955
- Lancement du programme élargi de vaccination pour les enfants (1974)
- Liste des médicaments essentiels (1977)
- La déclaration Alma Ata (1978) qui mobilise des gens dans le monde entier pour atteindre l'objectif "santé pour tous"
- Eradication de la variole (1979)



# Etapes importantes

- Objectifs du Millénaire pour le développement (2000)
- Lancement avec ONUSIDA de l'initiative 3x5, visant à assurer un traitement antirétroviral à 3 millions de personnes avant la fin de 2005
- SRAS (2003) H1N1 (2009) – investigations internationales coordonnées par l’OMS avec l’aide du réseau mondiale d’alerte
- La convention-cadre de l’OMS pour la lutte anti-tabac (2005)
- Règlement sanitaire international (2007), les systèmes de réponses humanitaires et sanitaires renforcés
- +6 millions de personnes ont accès aux traitements anti rétroviraux (2010)
- Ebola 2015 & co... (réforme OMS et création Alliance CSU 2030)
- Objectifs pour un développement durable (ODD – 2030)
- Coronavirus Covid-19 leadership de l’OMS au niveau international



## Un leadership fort de la part du Directeur Général de l'OMS



# Financement de l'OMS <sup>[2/2]</sup>

Table 2. Segments of the Proposed programme budget 2022–2023 and comparison with the approved Programme budget 2020–2021 (US\$ million)

Budget segment	2020–2021 Approved Programme budget (US\$ million)	2022–2023 Proposed programme budget (US\$ million)	Change
Base programmes	3 768.7	4 364.0	16%
Polio eradication	863.0	558.3	-35%
Special programmes	208.7	199.3	-4%
Emergency operations and appeals	1 000.0	1 000.0	0%
<b>Grand total</b>	<b>5 840.4</b>	<b>6 121.7</b>	<b>5%</b>

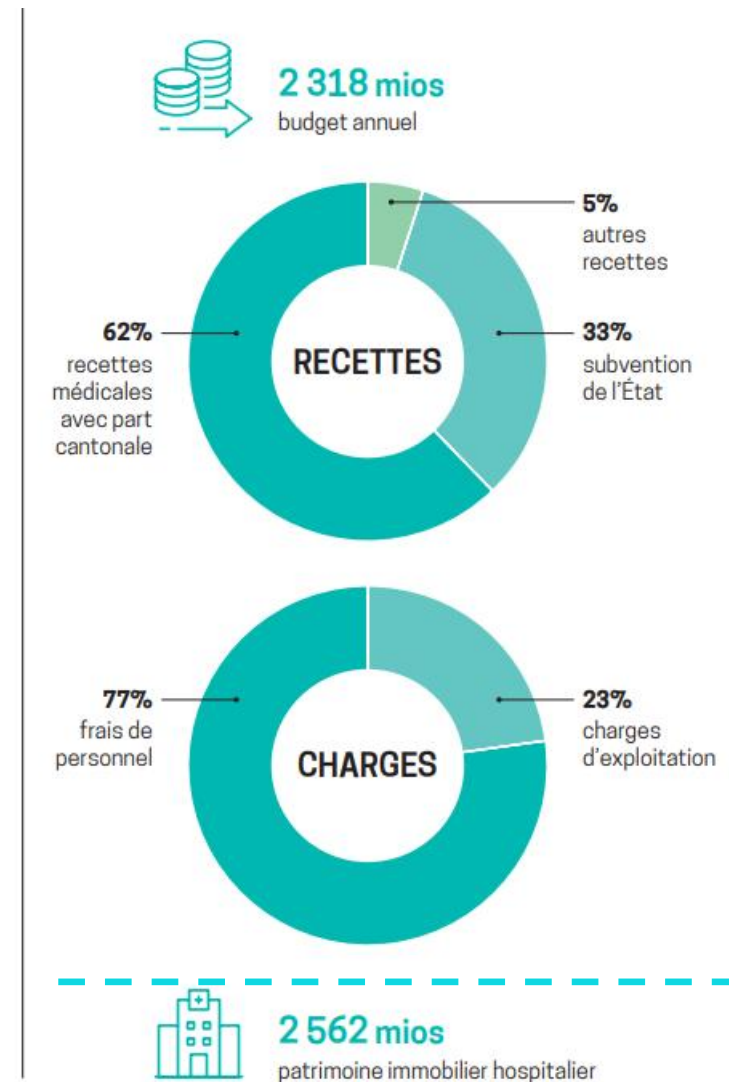
**45% pays**  
**25% Bureaux régionaux**  
**30% Siège**

Source : WHO Programme Budget 2022-2023

**Le budget de l'OMS sera pour la période 2026/2027 de 2.1 milliards USD par an**

**En Belgique, le budget de la santé est actuellement d'environ 45 milliards d'euros par an dont 77% à charge de l'Etat...**

**En 2023, le budget de l'Hôpital Universitaire de Genève est de 2.3 milliards CHF**



## War economies and collapsing health systems



Every 1% increase in military spending drives a 0.62% reduction in public health spending.<sup>1</sup> This trade-off is more intense in low-income countries, where a 1% increase in military spending results in a 0.962% drop in health spending.<sup>1</sup>

As global defence budgets surge to historical highs amid escalating conflicts in the Middle East, Ukraine, and beyond, this is not an abstract equation; it is a daily reality for the one in six people worldwide now living under active conflict.<sup>2</sup> Evidence from 1990 to 2017 links conflict to an estimated 29.4 million excess deaths from indirect causes alone, such as disrupted health services.<sup>3</sup> These costs occur through specific and compounding means.<sup>4</sup>


First, through direct destruction: WHO has verified 13 attacks on health facilities in Iran since conflict began in February, 2026, with nearly 1000 deaths reported in Iran, and 50 in Lebanon. Lebanon witnessed the closure of 43 primary health-care centres and two hospitals.<sup>4</sup>

Second, through supply chain collapse: WHO's Global Health Emergencies Logistics Hub in Dubai is on hold, with US\$18 million in humanitarian health supplies blocked, affecting more than 50 emergency supply requests from 25 countries.<sup>4</sup> This blockade includes \$6 million worth of medicine for Gaza that cannot be delivered.

The final way these costs are incurred is through economic warfare (ie, sanctions). Despite formal humanitarian exemptions, sanctions in Iran have caused critical shortages of medicines and medical supplies, with a documented 10–20% foreign currency shortfall for pharmaceutical procurement predating the first strike.<sup>5</sup>

Universal health coverage (UHC) frameworks remain largely blind to this reality. UHC indices measure coverage and financial protection against baselines that assume functioning economies. However, conflict-affected countries are penalised in these metrics for the direct fiscal consequences of war economics (appendix), as countries with higher conflict indices have greater reductions in health spending compared with countries not affected by war. Furthermore, external health aid to low-income and middle-income countries is collapsing by 30–40%,<sup>6</sup> placing affected countries in an acute health budget deficit and making out-of-pocket health spending the only way to finance health systems.

Peace is essential for UHC. UHC should be maintained during periods of conflict, as this is when demand for medical services increases exponentially. Furthermore, we argue that sanctions and blockages should be recognised as quantifiable social determinants of health. Health facilities must be protected, and access to humanitarian supplies must not be impeded. Health cannot—and should not—be overlooked in the economies of war.



We declare no competing interests.

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www.thelancet.com Vol 407 April 11, 2026

# L'Organisation mondiale de la Santé

## Why is it important?

WHO is indispensable in

- ✓ preventing, detecting, and responding to global health threats,
- ✓ ensuring equitable access to healthcare, and
- ✓ setting international health policies.

No other organization can fulfil this role comprehensively. If WHO did not exist, the world would need to create it to avoid chaos in global health governance, disease control, and emergency response. Its role as an umbrella institution and ability to provide a safe, non-partisan space for all countries to meet, debate, negotiate and agree ensures that no country is left behind in tackling health challenges that transcend borders.

## Quelle est son importance ?

L'OMS est indispensable pour

- ✓ prévenir, détecter et répondre aux menaces sanitaires mondiales,
- ✓ garantir un accès équitable aux soins de santé et
- ✓ définir des politiques sanitaires internationales.

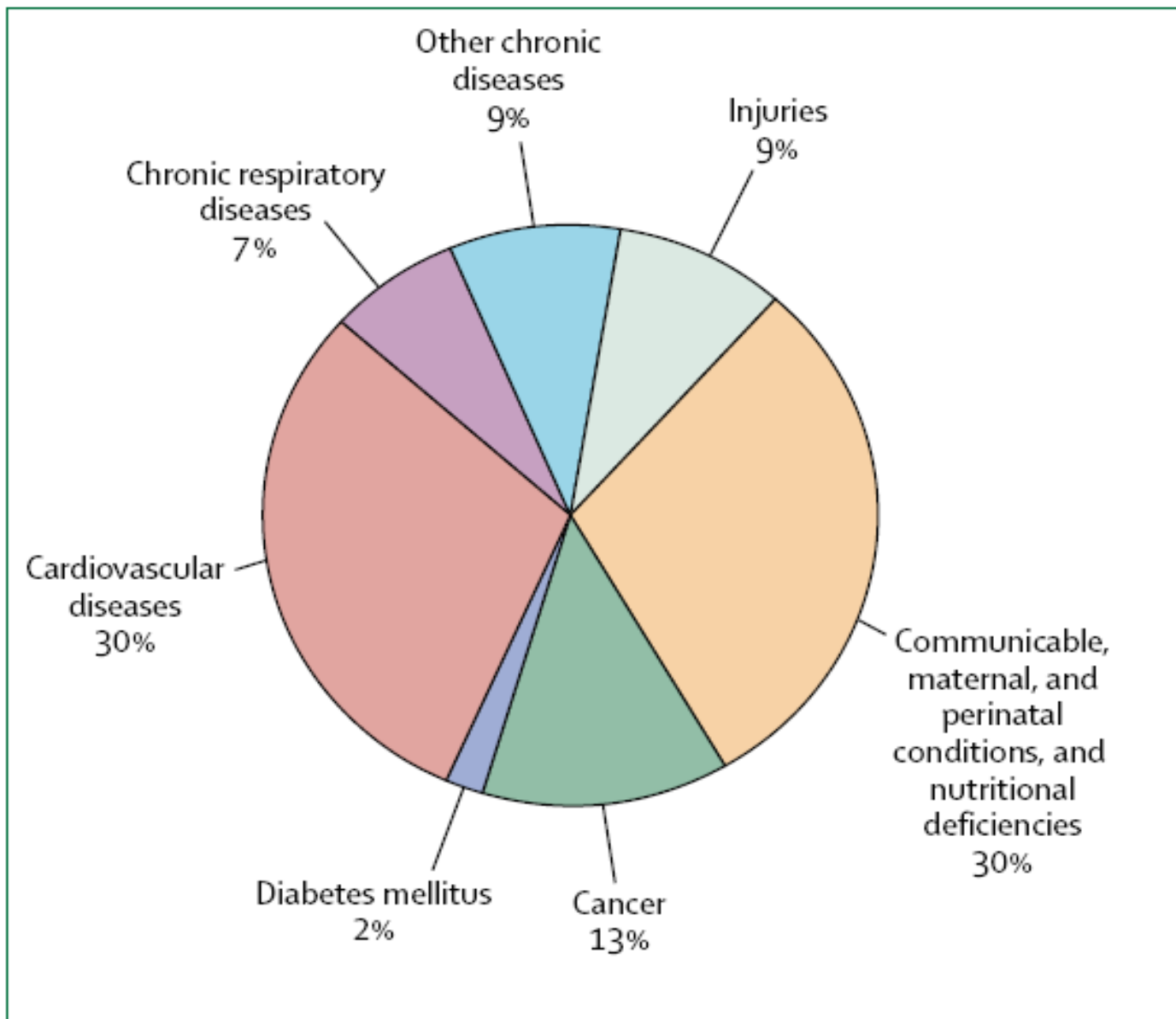
Aucune autre organisation ne peut remplir ce rôle de manière complète. Si l'OMS n'existait pas, le monde devrait la créer pour éviter le chaos dans la gouvernance sanitaire mondiale, la lutte contre les maladies et les interventions d'urgence. Son rôle d'institution faîtière et sa capacité à offrir à tous les pays un espace sûr et non partisan pour se réunir, débattre, négocier et se mettre d'accord garantissent qu'aucun pays n'est laissé pour compte dans la lutte contre les problèmes de santé qui dépassent les frontières.



**Pause - Questions**

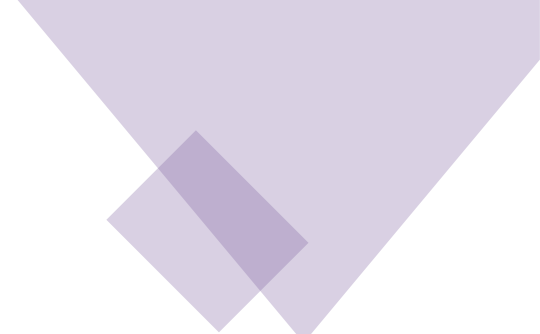
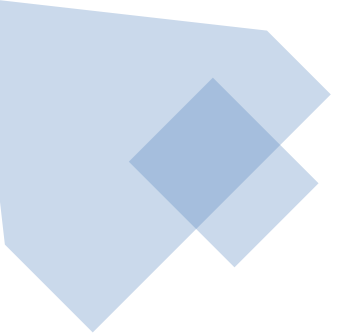
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# **LES GRANDS PROBLÈMES DE SANTÉ DANS LE MONDE: QUELQUES TENDANCES...**



**NB : Selon Our World in Data, en 2023, le nombre de décès était de 62 millions.**

Figure 1: Projected global distribution of total deaths (58 million) by major cause, 2005



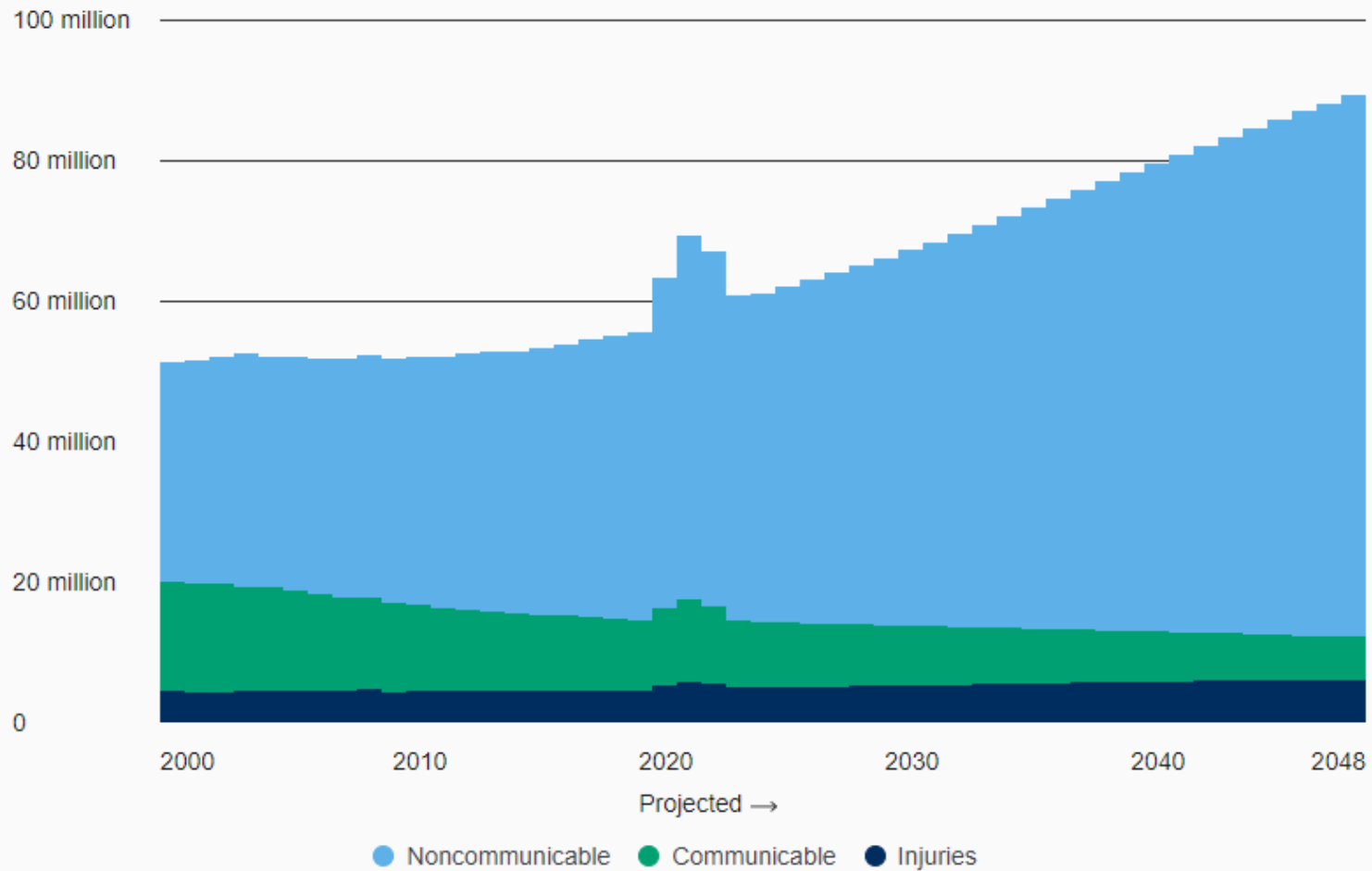
Between 2000 and 2020, the global number of maternal deaths fell from 447 000 to 287 000 and the **global maternal mortality ratio** decreased from 339 deaths per 100 000 live births to 223 deaths per 100 000 live births. Both decreased by more than one third.

The **global under-five mortality rate** saw even faster progress. It was reduced by half between 2000 and 2021, from 76 deaths per 1000 live births to 38 deaths per 1000 live births. In 2000, there were 9.9 million deaths in children under five. In 2021, this number had fallen to 5 million.

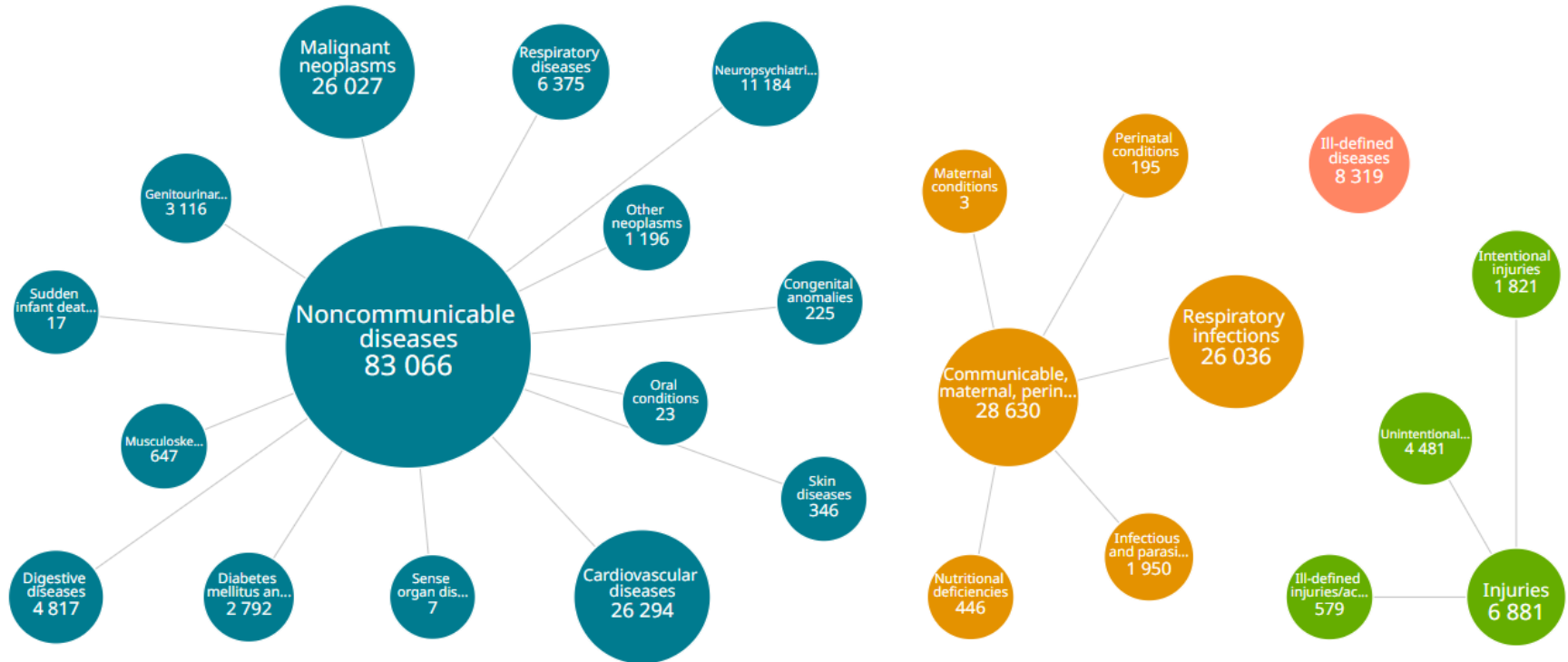
Almost half of these 5 million deaths occurred during the very first month of a baby's life. The **global neonatal mortality rate** – infant deaths within the first month of life – improved from 31 deaths per 1000 live births (2000) to 18 deaths per 1000 live births (2021).

## By 2048, NCDs are projected to cause the vast majority of global deaths

Select region:

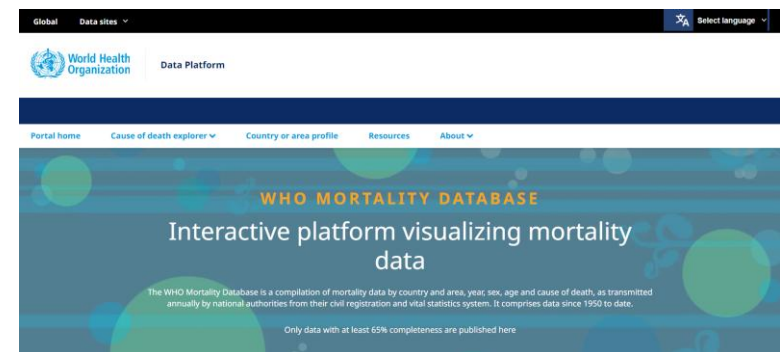


## Overview of the distribution of causes of total deaths grouped by category

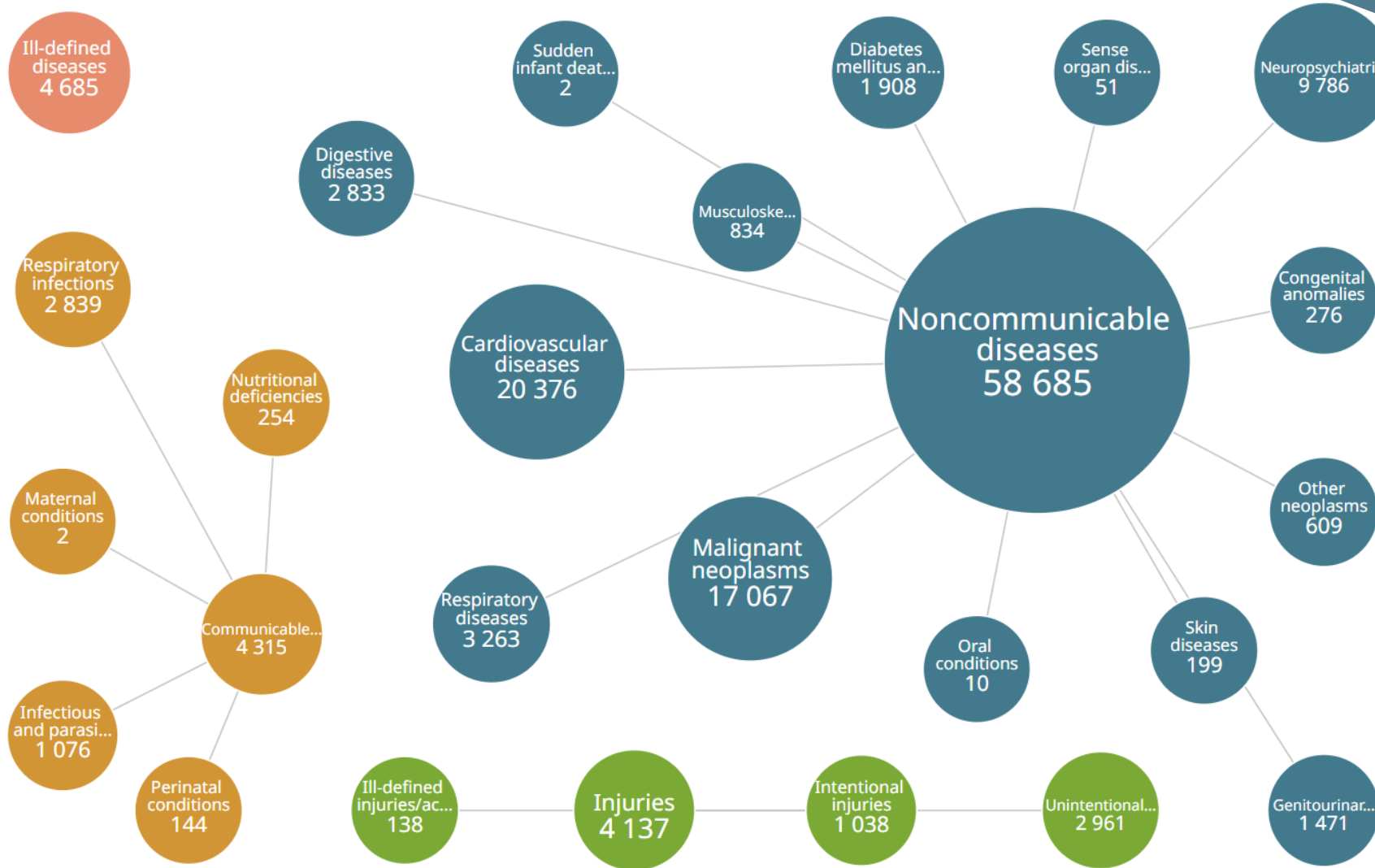


Data presented for latest year available:  
Belgium - 2020

Source: WHO Mortality Database (accessed 30 April 2024)



## Overview of the distribution of causes of total deaths grouped by category



Data presented for latest year available:

Switzerland - 2023

Accessed 25 mai 2026

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# **DÉFIS ET PERSPECTIVES POUR L'OMS**

# Défis et perspectives

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Après 75 ans d'existence l'OMS fait aussi face à de nombreux défis:

- Défis en terme de santé publique
- Défis concernant la place de l'OMS dans le paysage de la santé globale

# Défis en terme de santé publique 1/2

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- Les maladies non-transmissibles: elles sont la cause principale des maladies et de mortalité dans le monde (36 millions dont 48% maladies cardiovasculaires, 21% cancers, 12% maladies respiratoires, 3% diabète)
- Vieillessement de la population
- Urbanisation: plus de 50% de la population mondiale vit dans des villes à présent
- Migration et mobilité des populations

# Défis en terme de santé publique 2/2

- Agitation sociale : conflits internes et guerres, instabilité conditions socio-économiques
- Usage accidentel ou intentionnel des agents biologiques, chimiques ou nucléaires
- Désastres naturels : inondations, sécheresse, cyclones, tremblements de terre
- Epidémies et pandémies (health security) – SRAS, H1N1, MV Ebola, MV ZiKa, COVID-19, Monkeypox,...

# The changing global context: Challenges & opportunities



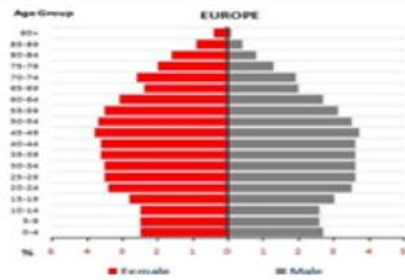
SDGs



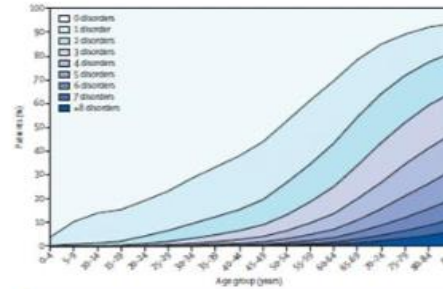
Globalization



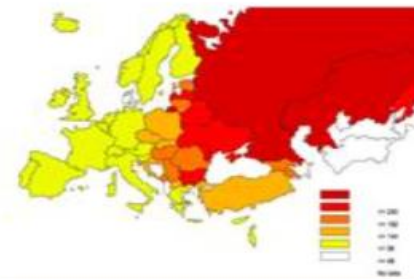
Migration



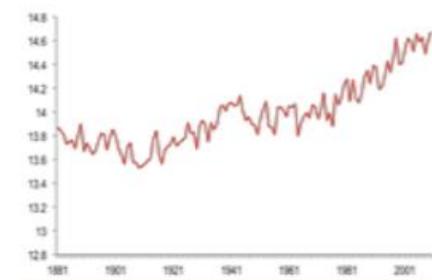
Ageing



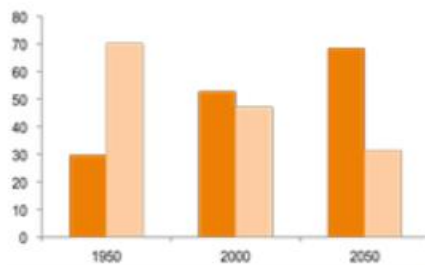
Multi-morbidity



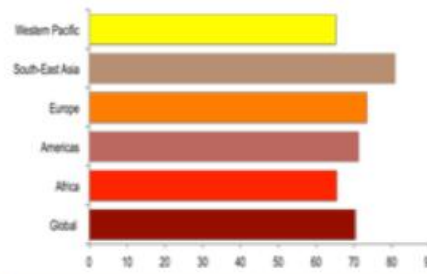
NCDs



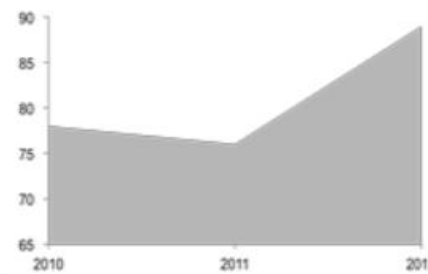
Climate change



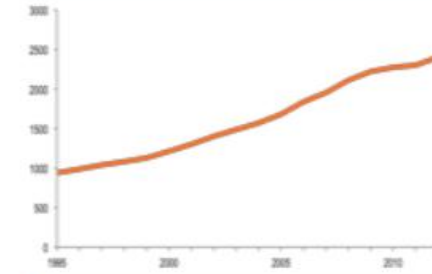
Urbanization



Citizen voice



Innovation



Rising costs

Source: WHO Global Health Observatory Data Repository, 2015

# Health & well-being in an increasingly complex world

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**Climate change &  
environ. degradation**



**Human migration &  
displacement**



**Zoonotic  
spillover events**



**Geopolitical  
change**



**Evolving science &  
technology**



**Demographic  
shifts**

# Défis en terme de réponses 2/2

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"The availability of good medical care tends to vary inversely with the need for it in the population served"

*The inverse care law, The Lancet, 1971*

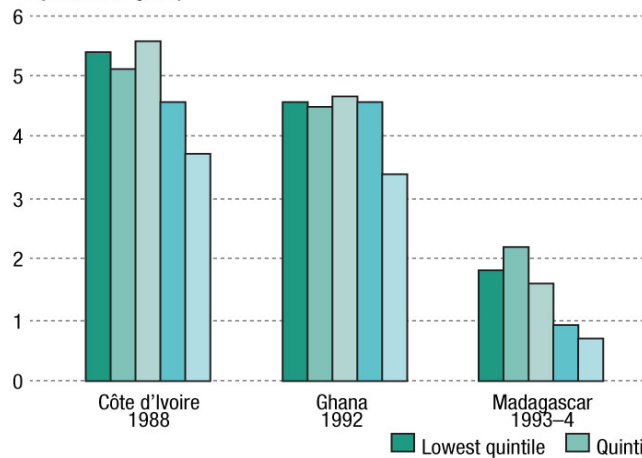
"More authorities are becoming aware that many campaigns for the eradication of diseases will have only temporary effects if they are not followed by the establishment of permanent health services in those areas, to deal with day-to-day work in the control and prevention of disease and the promotion of health. "

*Annual report of the Director-General of WHO, 1951*

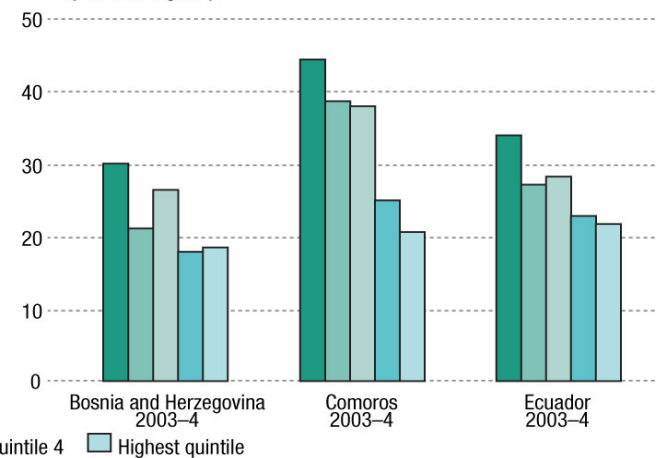


# Persistence d'inégalités entre pays ET dans tous les pays

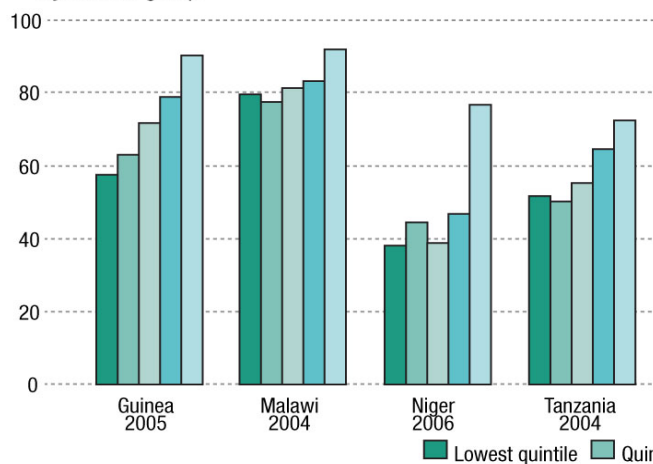
Per capita household spending on health as percentage of total household spending, by income group



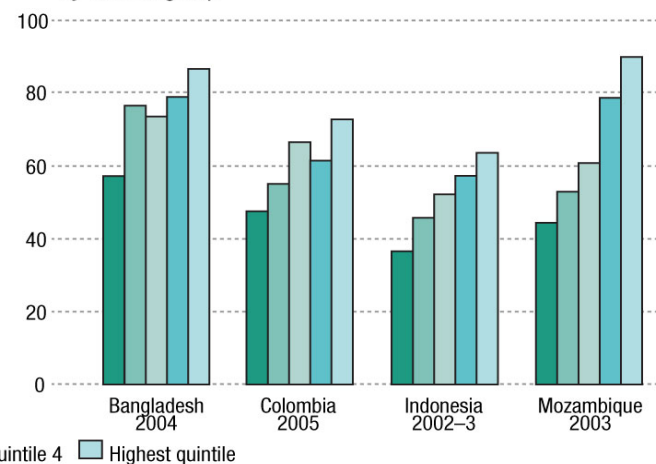
Mean time (minutes) taken to reach an ambulatory health facility, by income group



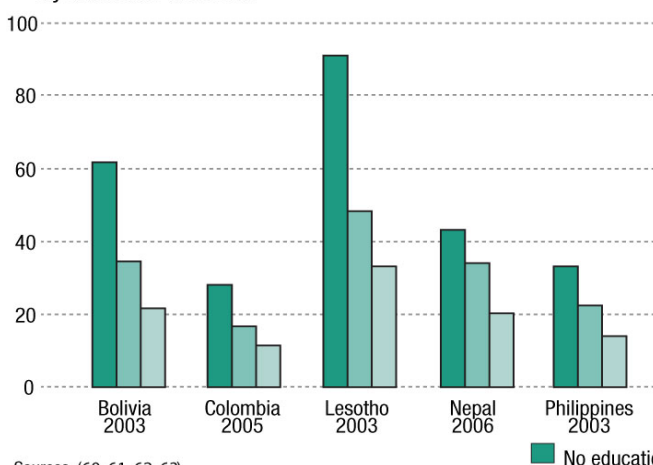
Women using malaria prophylaxis (%), by income group



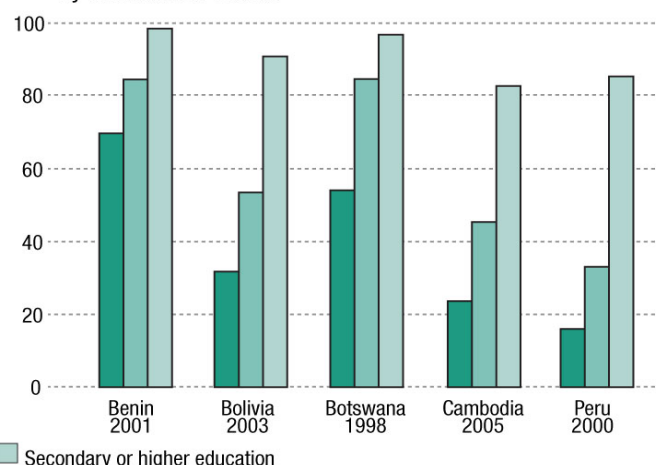
Full basic immunization coverage (%), by income group



Neonatal mortality rate, by education of mother

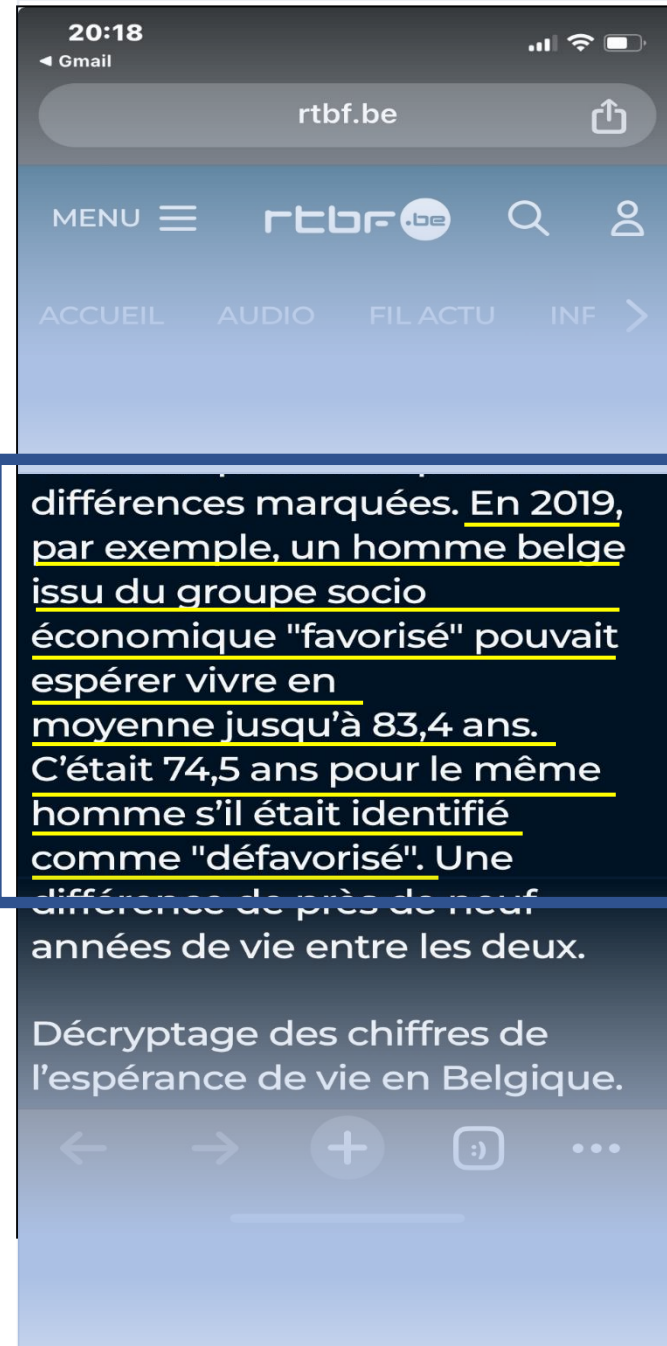


Births attended by health professional (%), by education of mother



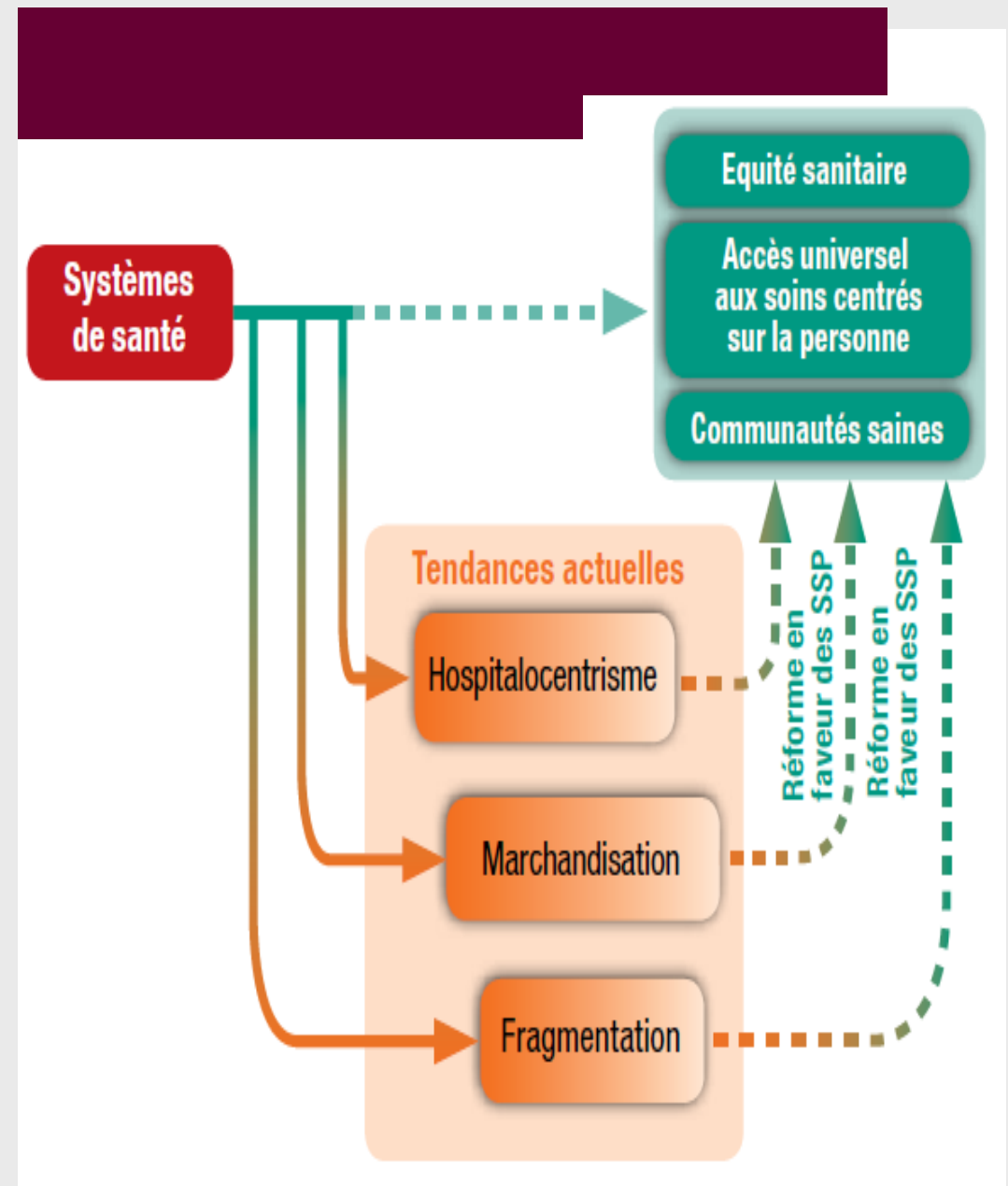
# Exemple concret : Inégalités en Belgique

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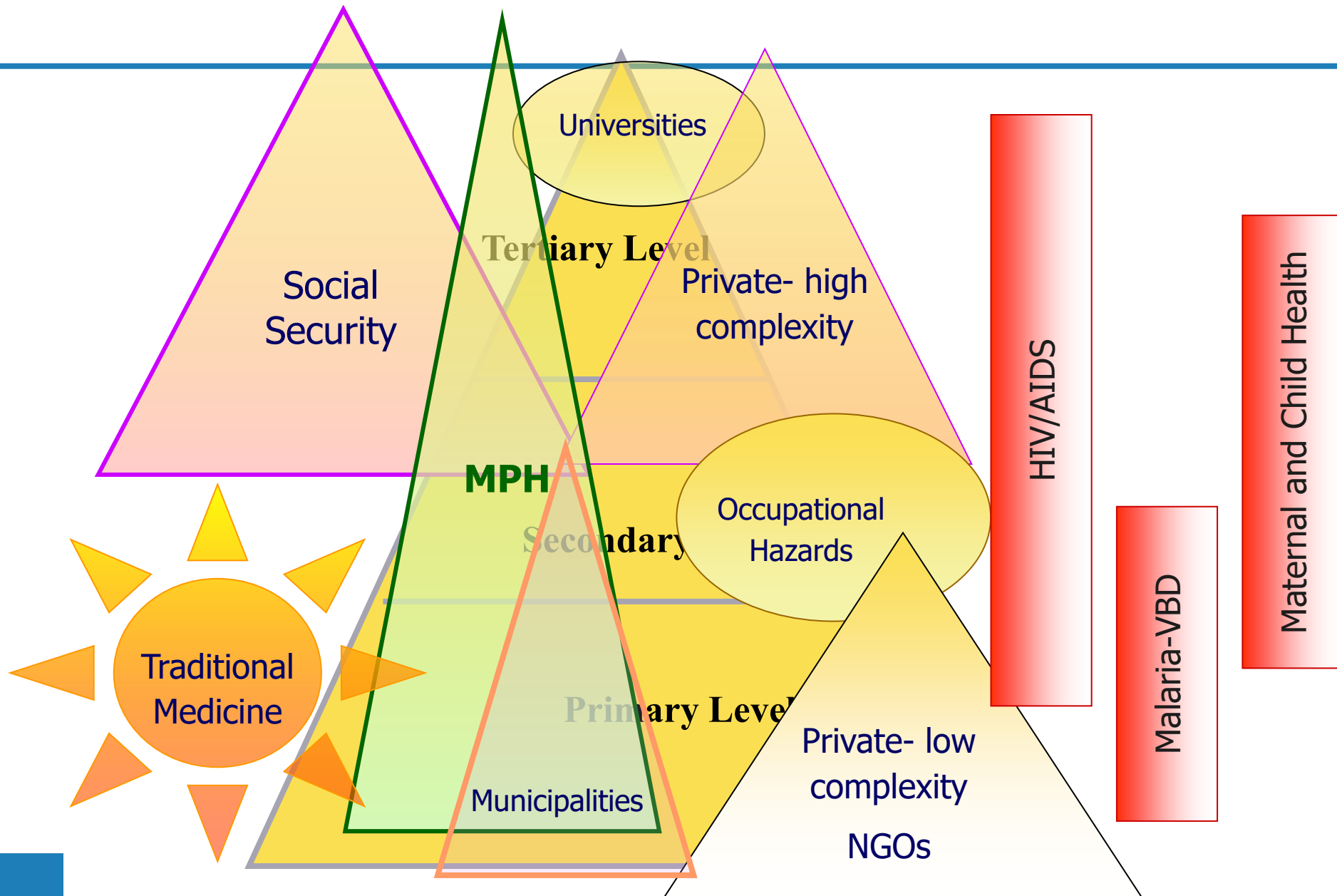


# Le Rapport sur la Santé dans le Monde 2008...

- Les systèmes de santé n'évoluent pas spontanément vers :
  - les valeurs des SSP (solidarité, participation, équité,...)
  - une rencontre optimale avec les attentes sociales des gens
  - une efficacité optimale
- Demande grandissante de la part des pays pour des réformes orientées vers les SSP



# Segmentation and fragmentation of health systems



# Défis concernant la place de l'OMS dans le paysage de la santé globale

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- Un nombre toujours plus important d'acteurs est présent: Fonds Mondial de lutte contre le sida, la tuberculose et le paludisme, GAVI (Alliance pour la vaccination), la fondation Bill et Melinda Gates, les initiatives présidentielles américaines (PEPFAR, Clinton Foundation,...), etc.
- Société civile : ONG, Associations de patients, parlementaires, groupes de pression,...

# NEW HEALTH INITIATIVES SINCE 2000...

**Stop TB Partnership**



President's Emergency Plan for AIDS Relief (PEPFAR)

Global Alliance to Eliminate Leprosy (GAEL)



Initiative on Public-Private Partnerships for Health



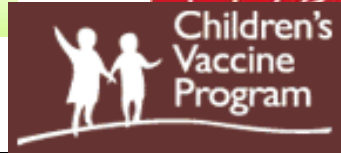
Accelerating Access Initiative

SECURE THE FUTURE®

Medicines for Malaria Venture



Global Polio Eradication Initiative



The European Malaria Vaccine Initiative



NetMark

Public-Private Partnership



Hope for African Children Initiative



Schistosomiasis Control Initiative

US Presidential Initiative  
**FIGHTING MALARIA**  
SAVING LIVES IN AFRICA

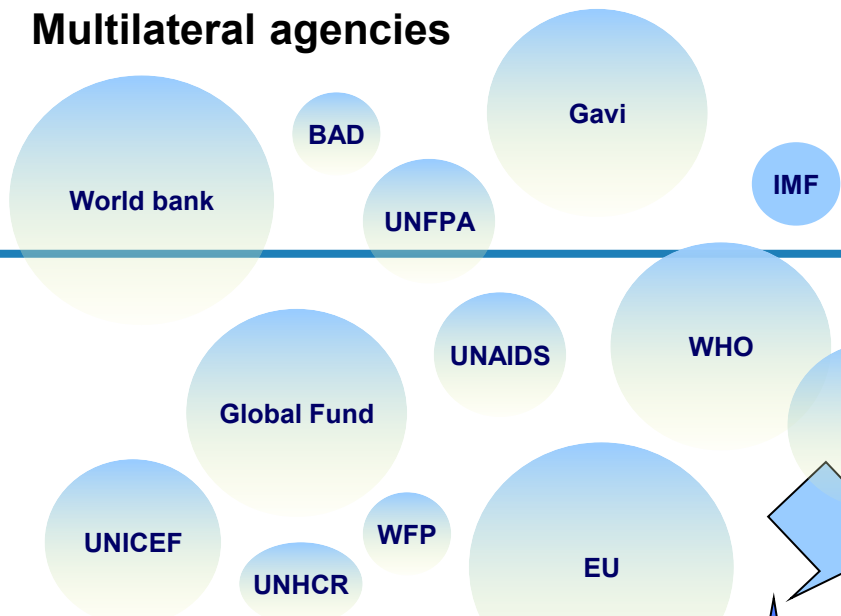


The Micronutrient Initiative

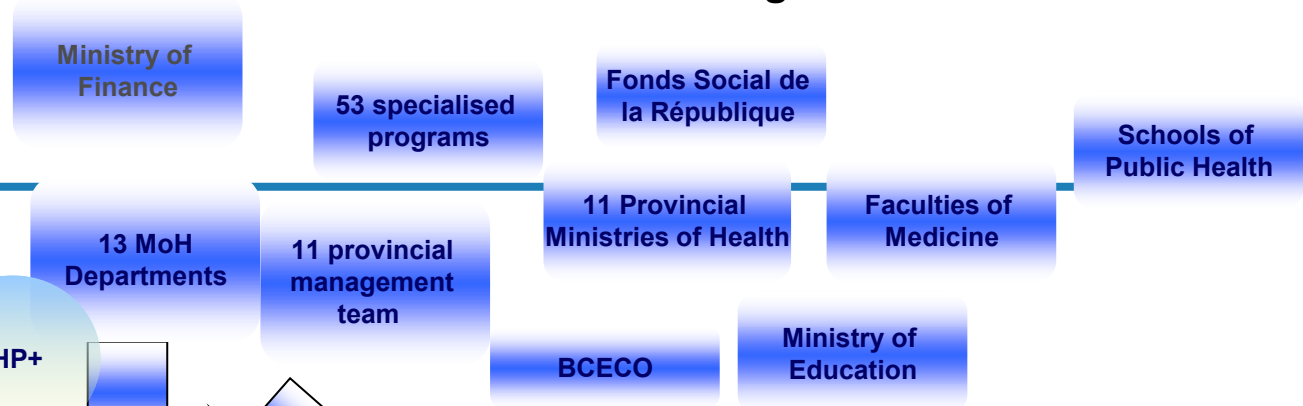


Pediatric DENGUE VACCINE INITIATIVE

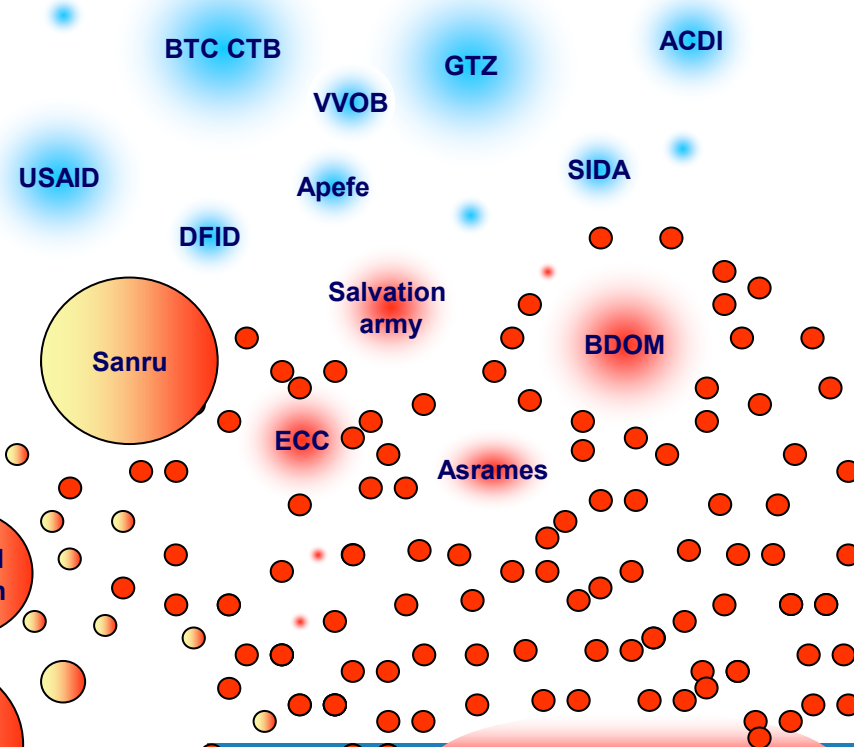
## Multilateral agencies



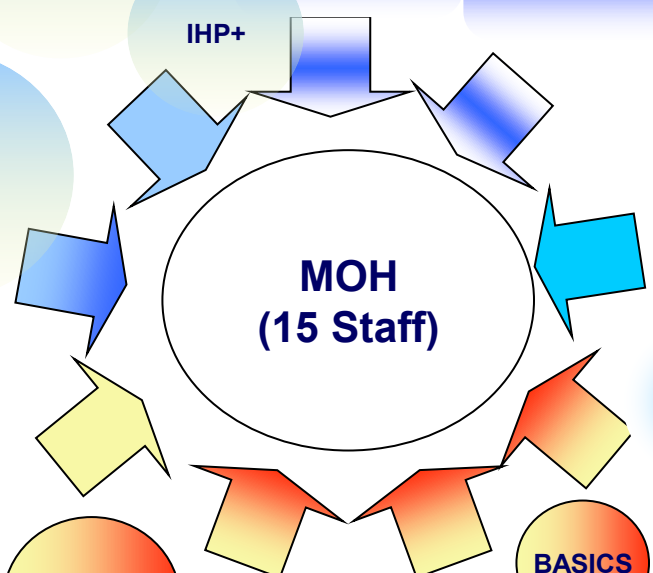
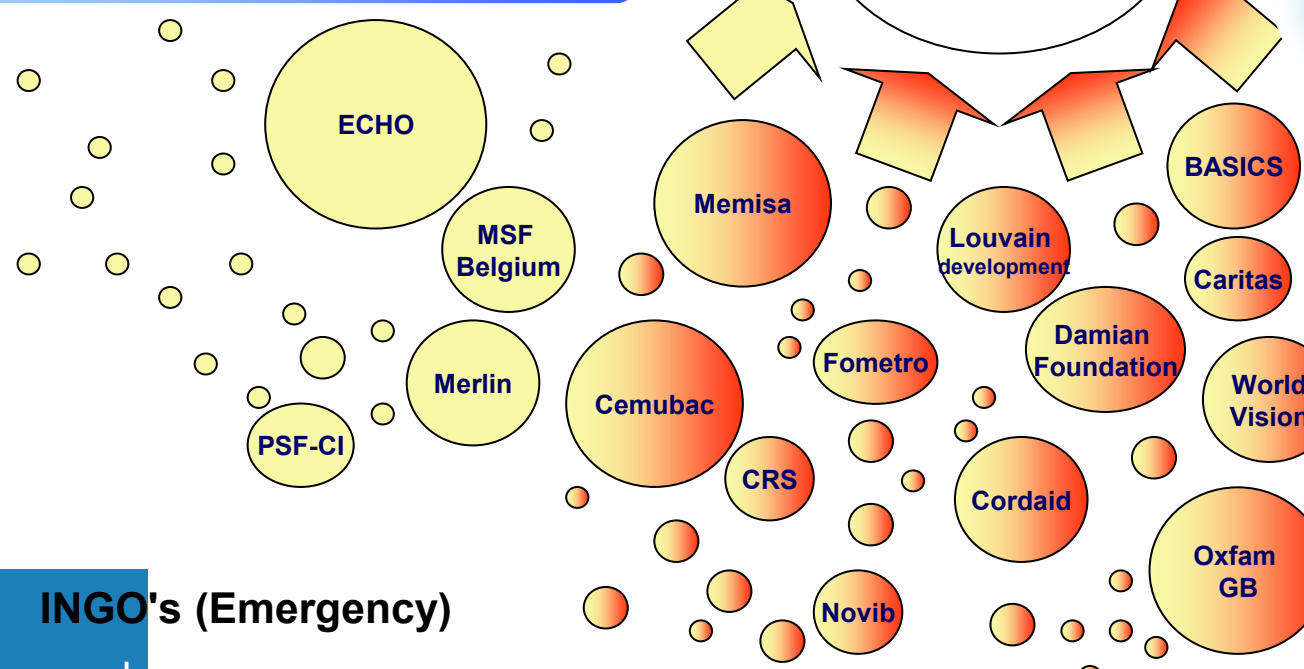
## State and Parastatal organisations



## Bilateral Funding / Technical agencies



## 13 Donor Government program coordination committees



## INGO's (Emergency)

## Int and Nat NGO's (Development and church related)

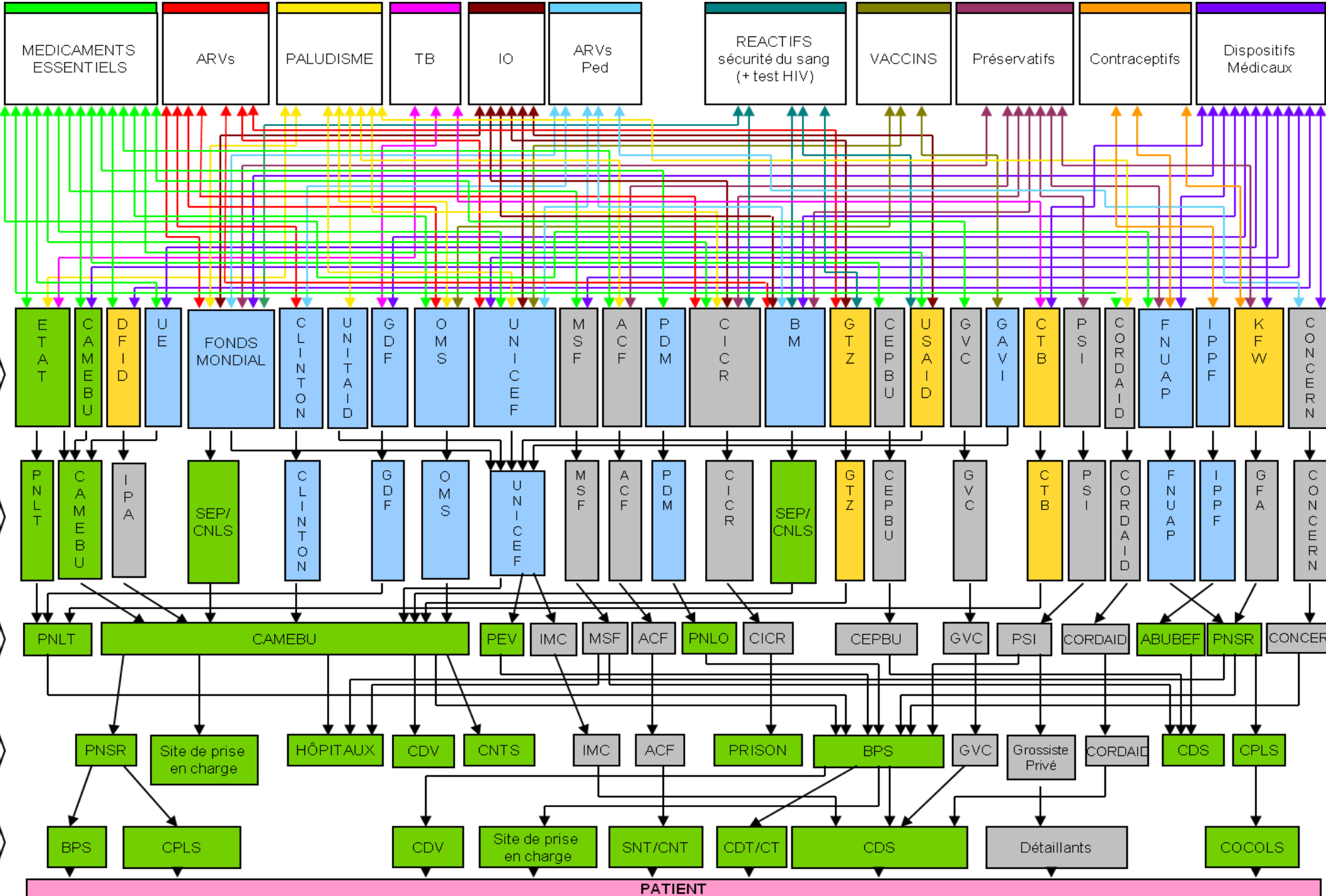
More than 200 health partners  
 Organisation mondiale de la Santé

[Source: Porignon, WHO, 2008]

# Systemes d'approvisionnement des produits pharmaceutiques au BURUNDI. Juillet 2007



République du Burundi  
Ministère de la Santé Publique



RESEARCH ARTICLE OPEN ACCESS

## Global Health Initiatives and Universal Health Coverage in Pakistan-Aligned for the Future?

Shehla Zaidi<sup>1,2</sup> | Shifa Salman Habib<sup>1</sup> | Asad Shoaib<sup>1</sup> | Zakir Shah<sup>1</sup> | Karl Blanchet<sup>3</sup> | Rosemary Jouhad<sup>3</sup> | Natasha Palmer<sup>4</sup> | Valery Ridde<sup>5,6</sup> | Sophie Witter<sup>4</sup>

<sup>1</sup>Aga Khan University, Karachi, Pakistan | <sup>2</sup>University College London, London, UK | <sup>3</sup>University of Geneva, Geneva, Switzerland | <sup>4</sup>Queen Margaret University, Edinburgh, UK | <sup>5</sup>Institut de Recherche pour le Développement, Marseille, France | <sup>6</sup>Cheikh Anta Diop University, Dakar, Senegal

(...) The findings highlight a context of expanding GHI mandate, despite Pakistan's trajectory towards middle income country status, but weak alignment with national primary health care (PHC) budgeting and planning processes. Country discourse acknowledged improved disease coverage but surfaced tensions with the off-budget parallel grant model, comprising of several GHI intermediaries, headquarters-driven planning and selective system support, that was not positioned to build sustainability resulting in duplicative resourcing, questionable value for money, clouding of accountability roles and poor preparedness for transition. (...)

(...) Les conclusions mettent en évidence un **contexte d'élargissement du mandat des Initiatives mondiales pour la santé (IMS)** et ce, malgré la trajectoire du Pakistan vers le statut de pays à revenu intermédiaire. Elles révèlent un **faible alignement** avec les processus nationaux de budgétisation et de planification des soins de santé primaires (SSP). Le discours national a reconnu l'**amélioration en matière de couverture des maladies**, mais a fait ressortir des tensions avec le **modèle parallèle de subventions** hors budget, comprenant plusieurs intermédiaires des IMS, une **planification dirigée par le siège** et un **soutien sélectif du système**, qui n'était pas en mesure d'assurer la durabilité, ce qui a entraîné un **double emploi des ressources**, un **rapport qualité-prix discutable**, un **brouillage des rôles** en matière de responsabilité et une **mauvaise préparation** à la transition. (...)

# Complexité :

## acteurs nombreux, multiples solutions

---

- Réponses globales, réponses spécifiques en termes de problèmes de santé (Sida, Ebola,...) et en termes de populations ciblées (femmes, enfants, vulnérables, urbain,...)
- L'OMS n'est pas une agence d'intervention. C'est une agence technique au sein de laquelle les considérations politiques sont importantes
- L'OMS doit fournir un cadre concerté avec les Etats membres pour assurer l'atteinte de l'objectif.

«Les lois d'organisation du vivant ne sont pas d'équilibre mais de déséquilibre...»

*Edgar Morin,  
Introduction à la pensée complexe.  
1990*

# Pause - Questions



**EN PRATIQUE, QUELLES SOLUTIONS ?  
QUE PROMEUT L'OMS ?**

# Les objectifs pour le développement durable

(Sustainable Development Goals) - ODD 2016-2030

## Objectifs de développement durable

Objectif 1. Éliminer la **pauvreté** sous toutes ses formes et partout dans le monde

Objectif 2. Éliminer la **faim** assurer la sécurité alimentaire, améliorer la nutrition et promouvoir l'agriculture durable

Objectif 3. Permettre à tous de **vivre en bonne santé** et promouvoir le **bien-être** de tous à tout âge

Objectif 4. Assurer l'accès de tous à une éducation de qualité, sur un pied d'égalité, et promouvoir les possibilités d'apprentissage tout au long de la vie

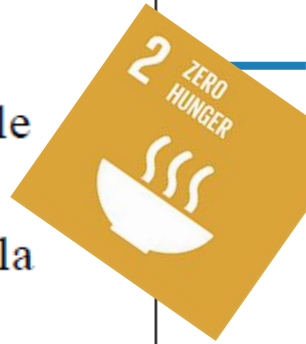
Objectif 5. Parvenir à l'égalité des sexes et autonomiser toutes les femmes et les filles

Objectif 6. Garantir **l'accès de tous à l'eau et à l'assainissement** et assurer une gestion durable des ressources en eau

Objectif 7. Garantir l'accès de tous à des services énergétiques fiables, durables et modernes à un coût abordable

Objectif 8. Promouvoir une croissance économique soutenue, partagée et durable, le plein emploi productif et un travail décent pour tous

Objectif 9. Bâtir une infrastructure résiliente, promouvoir une industrialisation durable qui profite à tous et encourager l'innovation





Objectif 10. Réduire les **inégalités** dans les pays et d'un pays à l'autre

Objectif 11. Faire en sorte que les villes et les établissements humains soient ouverts à tous, sûrs, résilients et durables

Objectif 12. Établir des modes de consommation et de production durables

Objectif 13. Prendre d'urgence des mesures pour lutter contre les changements climatiques et leurs répercussions\*

Objectif 14. Conserver et exploiter de manière durable les océans, les mers et les ressources marines aux fins du développement durable

Objectif 15. Préserver et restaurer les écosystèmes terrestres, en veillant à les exploiter de façon durable, gérer durablement les forêts, lutter contre la désertification, enrayer et inverser le processus de dégradation des terres et mettre fin à l'appauvrissement de la biodiversité

Objectif 16. Promouvoir l'avènement de sociétés pacifiques et ouvertes à tous aux fins du développement durable, assurer l'accès de tous à la justice et mettre en place, à tous les niveaux, des institutions efficaces, responsables et ouvertes à tous

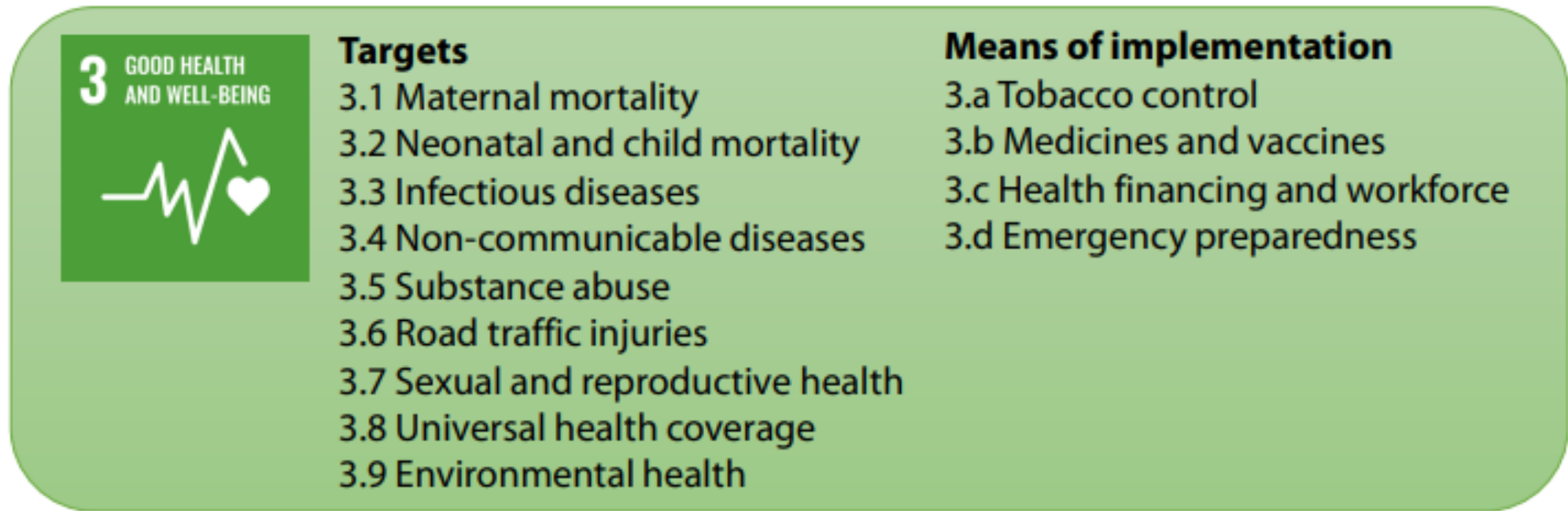
Objectif 17. Renforcer les moyens de mettre en œuvre le **Partenariat mondial** pour le développement durable et le revitaliser



Source: United Nations, 2015



## Figure 1 – SDG3 health and well-being targets

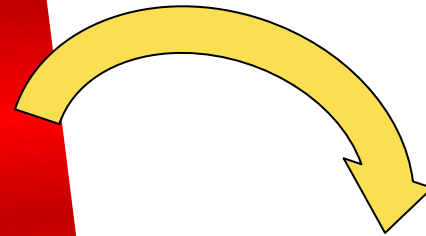


Source: ECA, based on WHO.

# Vers la Couverture sanitaire universelle...

'Universal health coverage means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.'

*Source: WHO, 2015*



'Broadly defined, UHC means all people receiving the quality health services they need, without being exposed to financial hardship. UHC involves three coverage dimensions – health services, finance and population – and is a dynamic, continuous process that changes in response to shifting demographic, epidemiological and technological trends, as well as people's expectations.'

*Source: WHO, 2017*

# Vers la Couverture sanitaire universelle...

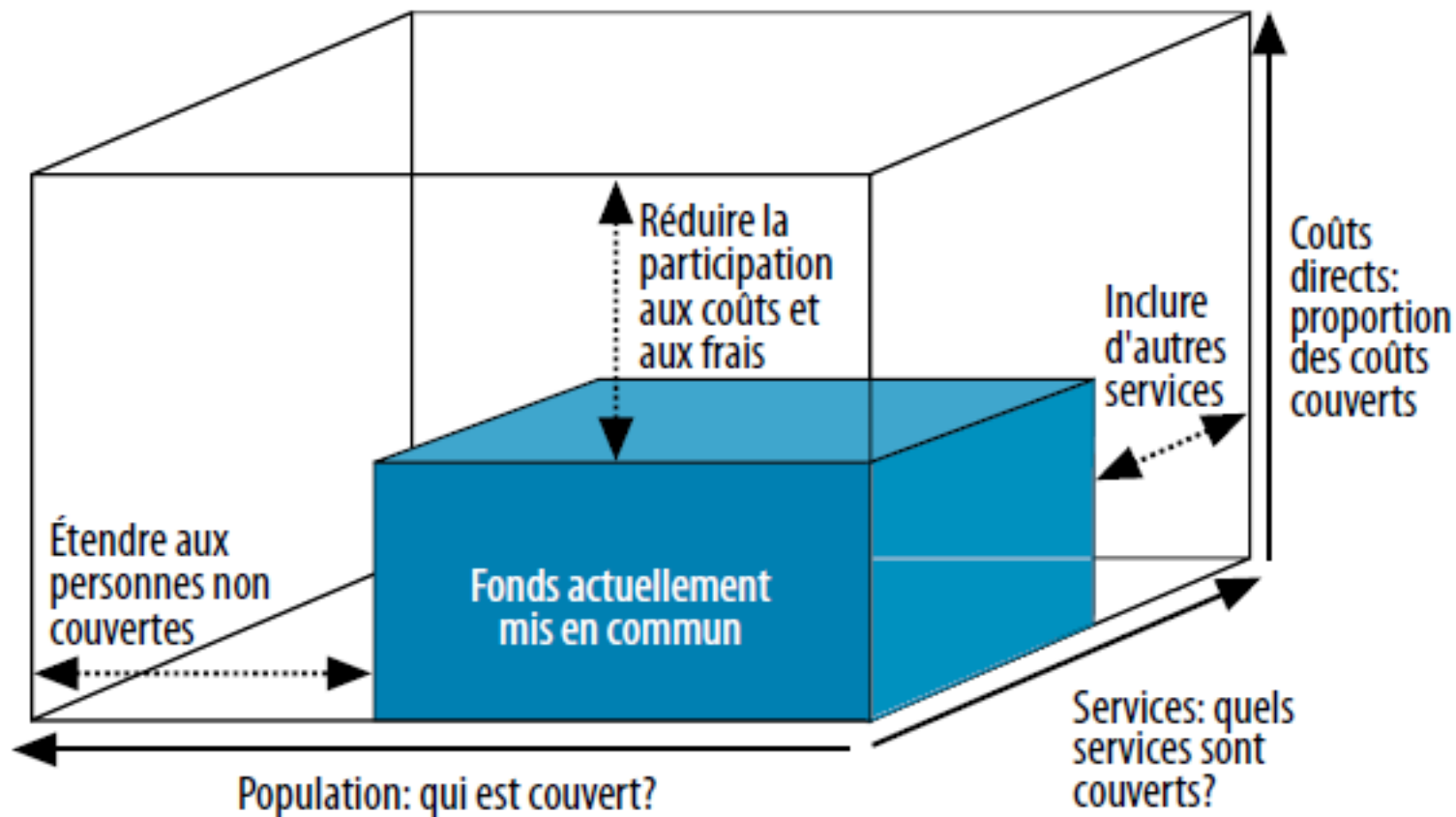
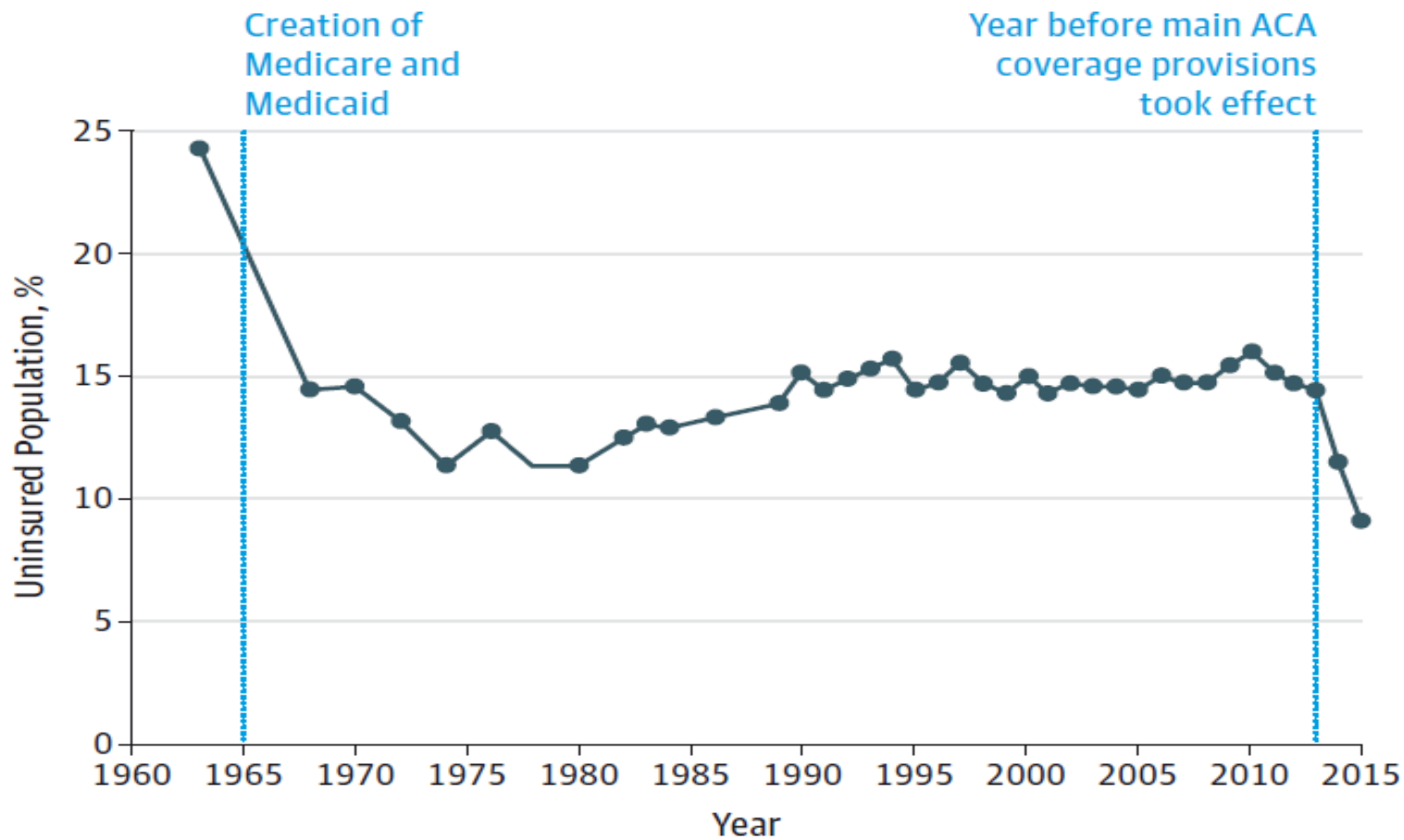


Figure 1. Percentage of Individuals in the United States Without Health Insurance, 1963-2015

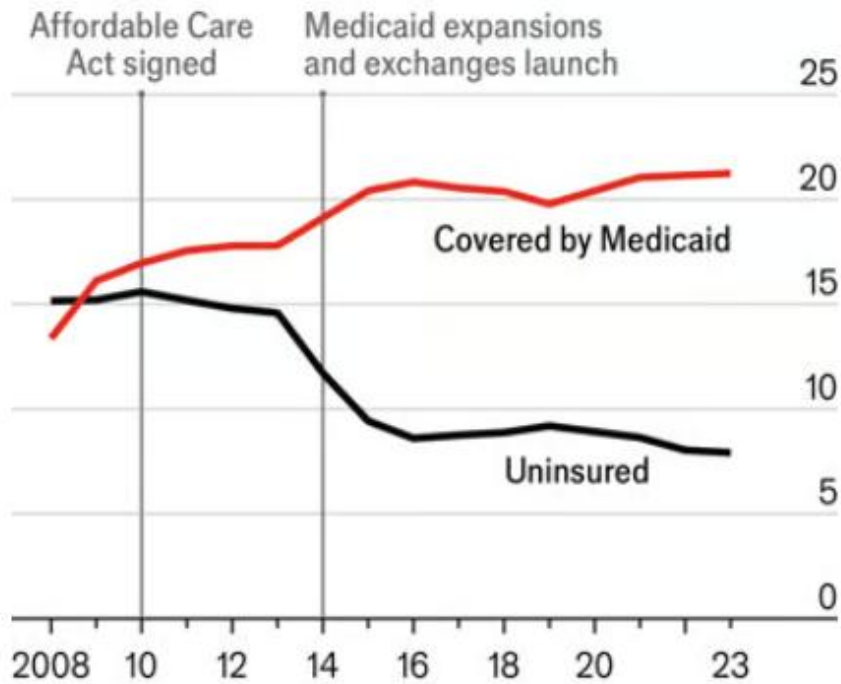


Source, Obama B, JAMA 2016

Data are derived from the National Health Interview Survey and, for years prior to 1982, supplementary information from other survey sources and administrative records. The methods used to construct a comparable series spanning the entire period build on those in Cohen et al<sup>8</sup> and Cohen<sup>9</sup> and are described in detail in Council of Economic Advisers 2014.<sup>10</sup> For years 1989 and later, data are annual. For prior years, data are generally but not always biannual. ACA indicates Affordable Care Act.

## US health insurance coverage

% of population

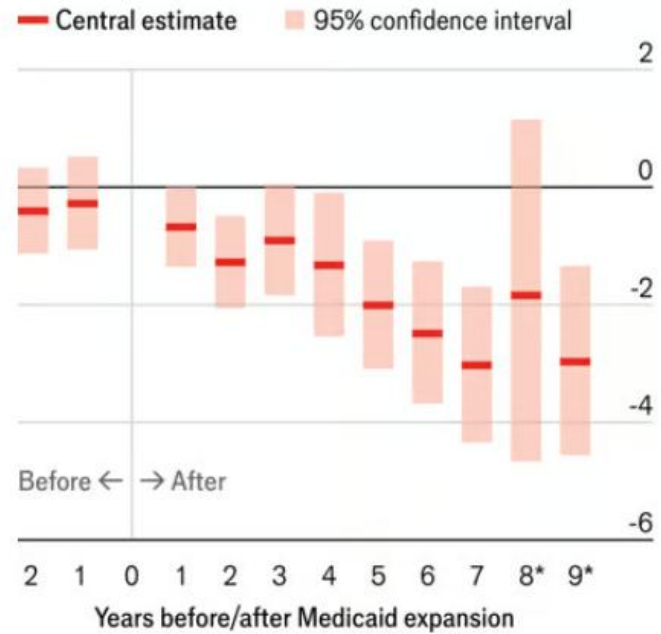


Source: KFF

CHART: THE ECONOMIST

## Change in deaths in states with Medicaid expansion, relative to states without

Per 10,000 low-income adults

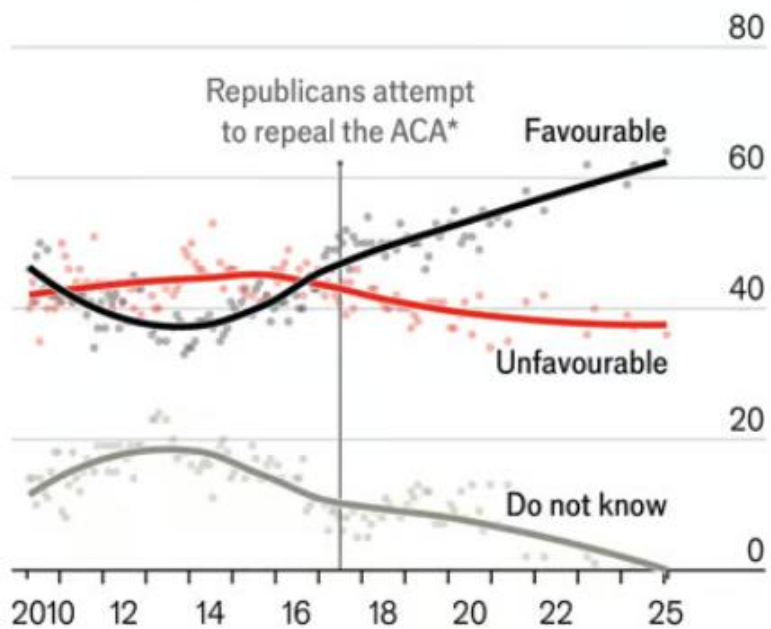


\*Coincided with the covid-19 pandemic in some states  
 Source: "Saved by Medicaid: new evidence on health insurance and mortality from the universe of low-income adults", by Angela Wyse and Bruce Meyer, 2023

CHART: THE ECONOMIST

## “Do you have a favourable or unfavourable view of the ACA\*?”

% responding



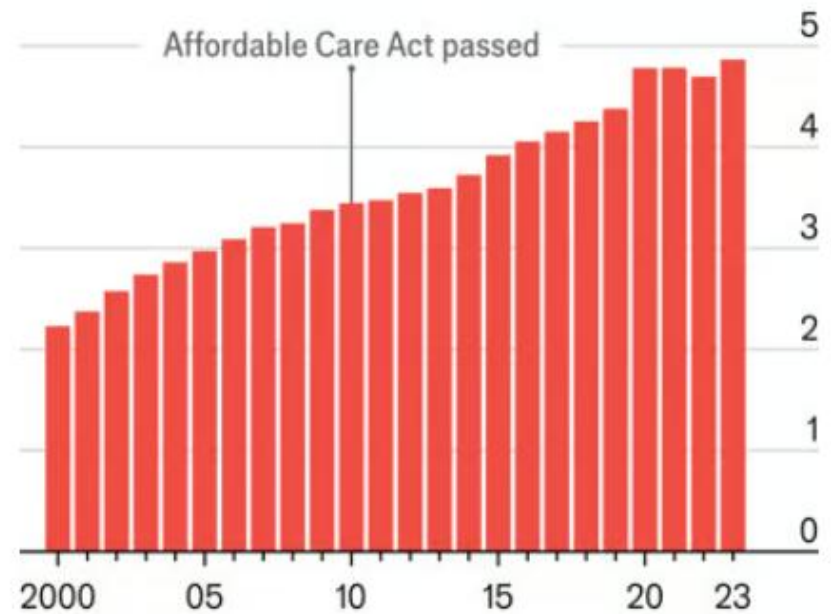
Source: KFF

\*Affordable Care Act

CHART: THE ECONOMIST

## Total national health-care spending

2023 prices, \$trn



Source: KFF

CHART: THE ECONOMIST

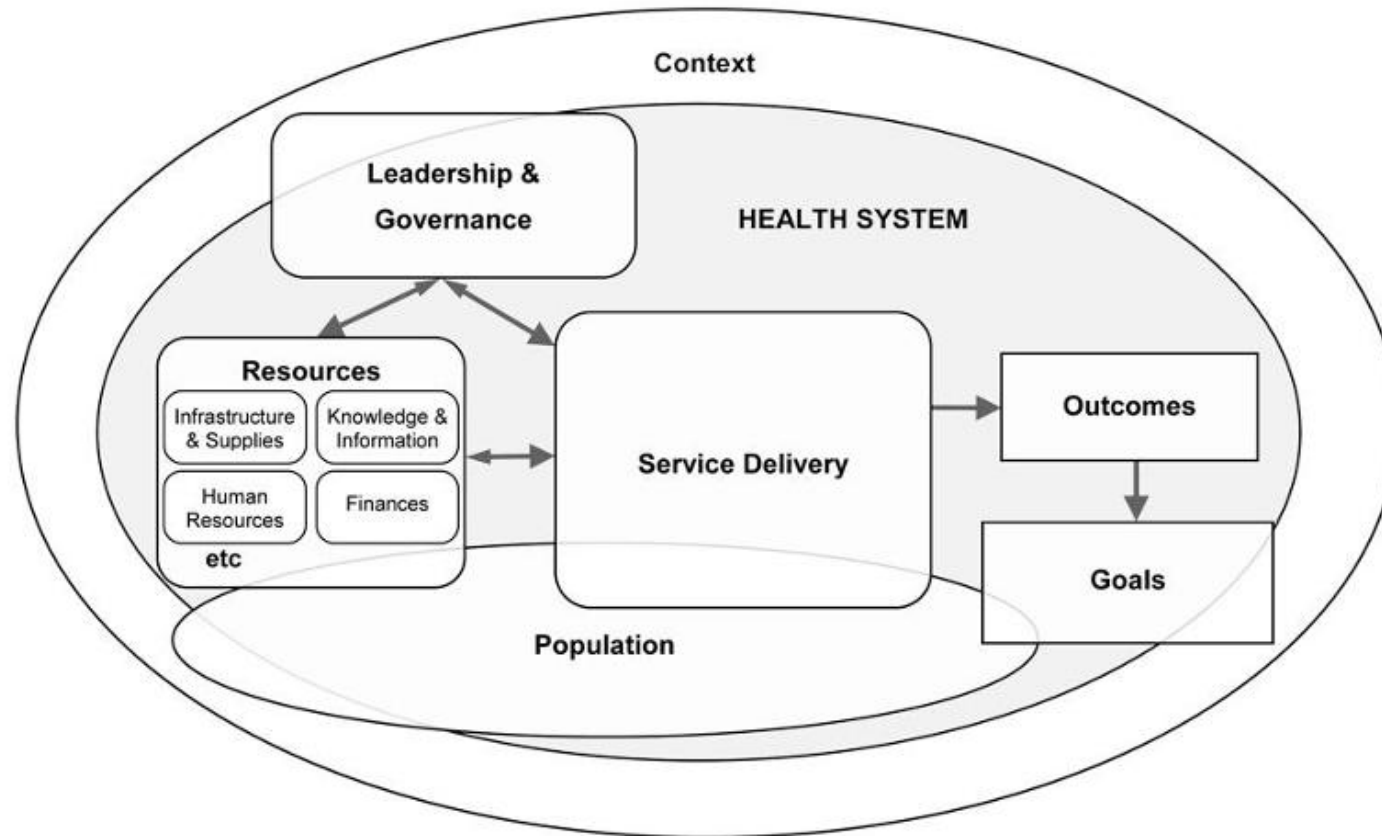


Figure 1: The health system dynamics framework

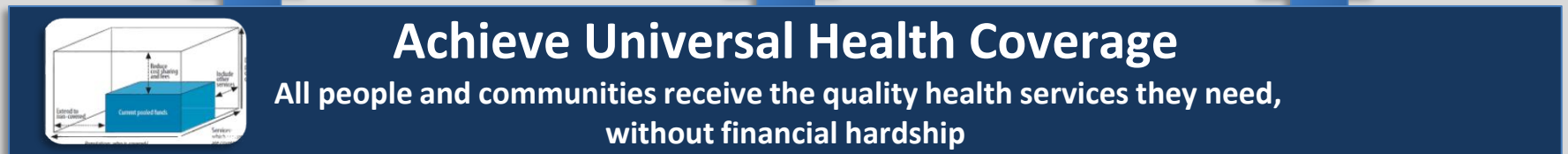
Source: ITM Antwerp (Van Olmen *et al*, Health, Culture and Society, 2012)

# HSS->UHC->SDG

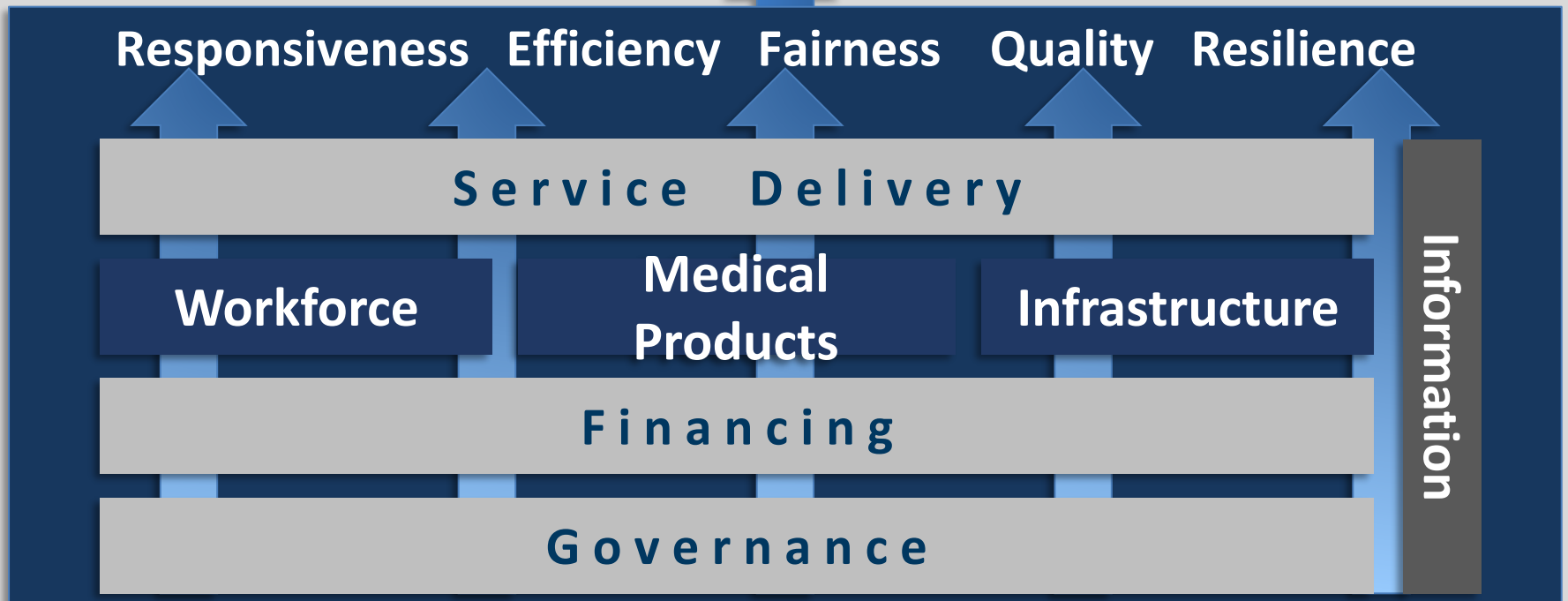
*SDGs  
(Impact)*



*UHC  
(Outcome)*



*Health System Strengthening  
(Input/Output)*



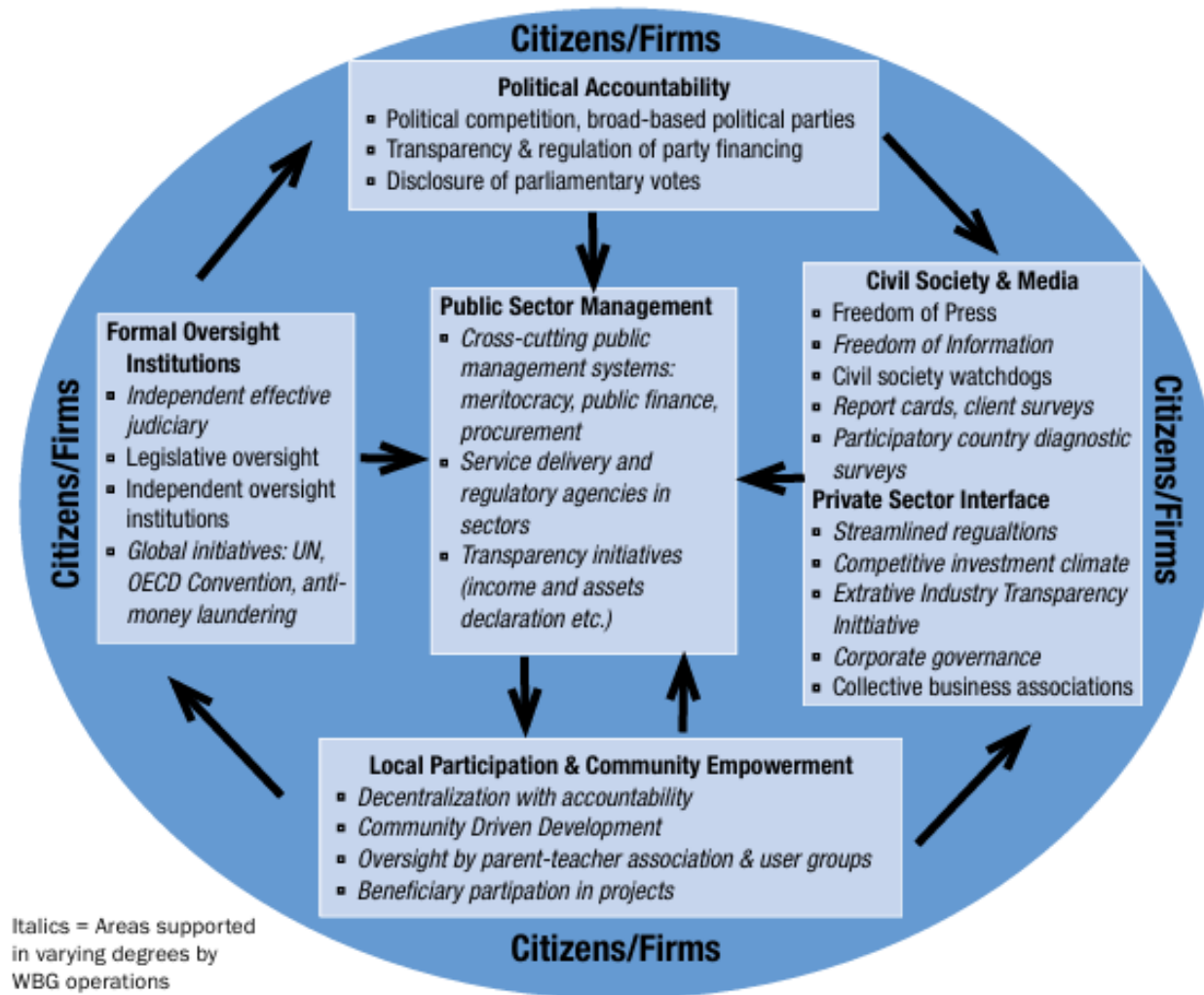
Le Groupe des Vingt (G20) est un forum de coopération entre certains pays qui représentent 80% du PIB mondial

## Une sensibilisation croissante des décideurs politiques au niveau mondial

La Déclaration<sup>1</sup> met en avant toute une série de domaines essentiels en matière de santé. Les dirigeants y soulignent l'utilité d'améliorer l'accès aux mesures de contrôle de la maladie et d'accroître les capacités de production, et y appellent à renforcer l'architecture mondiale de préparation et de riposte face aux urgences sanitaires en accordant un rôle central à l'OMS. Ils s'engagent à instaurer la couverture sanitaire universelle en mettant l'accent sur les soins de santé primaires et à poursuivre les progrès dans la lutte contre les maladies. Ils apportent leur soutien à l'approche « Une seule santé » et à la lutte contre la résistance aux antimicrobiens. Ils reconnaissent le rôle de la médecine traditionnelle et saluent la création de l'Initiative mondiale de l'OMS sur la santé numérique. Ils s'engagent à promouvoir les services de santé mentale. Enfin, ils réaffirment leur appui au groupe de travail ministériel conjoint sur les financements de la santé et au Fonds de lutte contre les pandémies.

<sup>1</sup> G20 Leaders Declaration, Dehli 2023

Figure 1: Scope of Governance and Governance Interventions

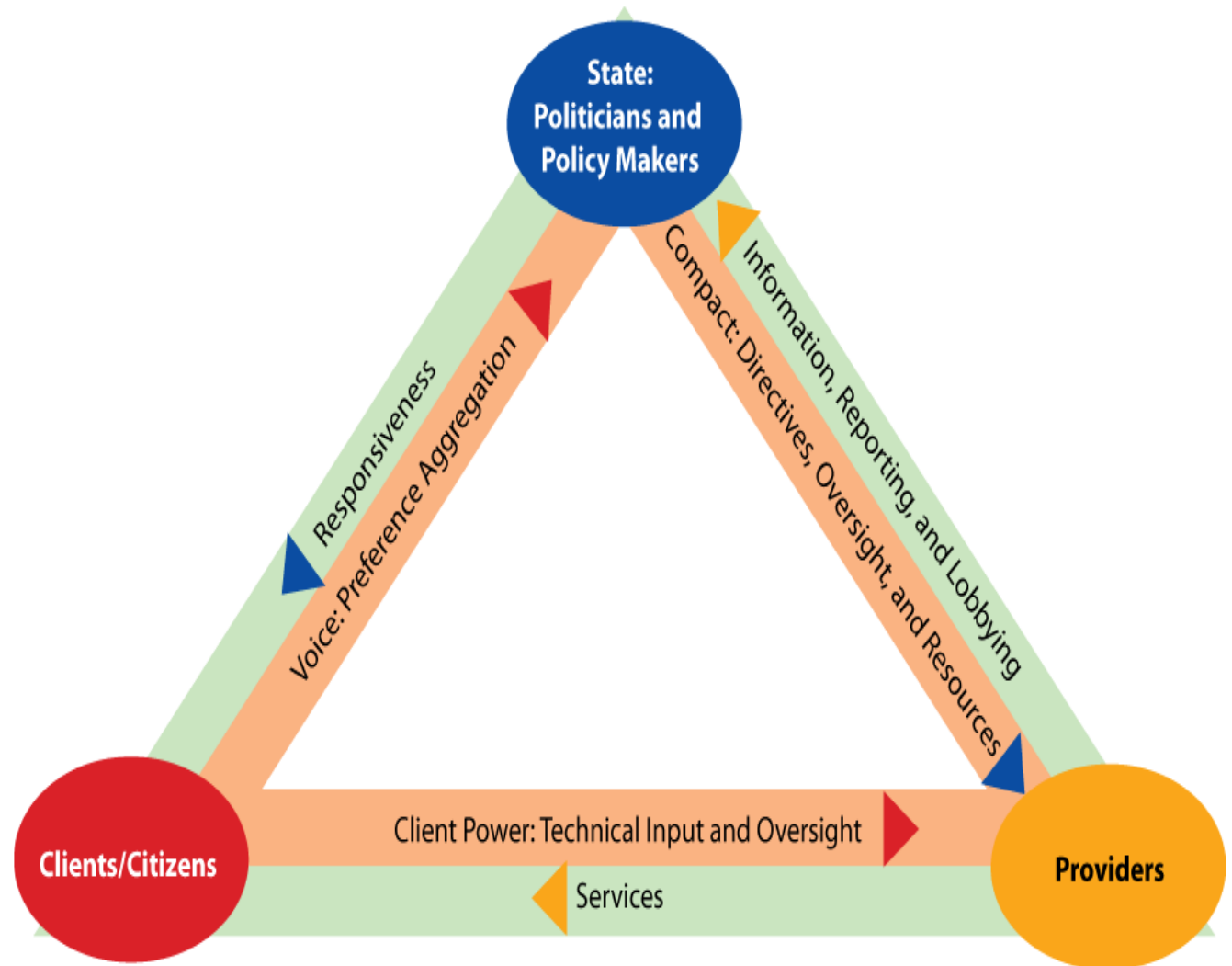


Source: Pradhan, World Bank 2006

# Gouvernance: un cadre de réflexion...

La gouvernance est la manière dont s'établissent et fonctionnent les règles et mécanismes relatifs aux rôles et responsabilités entre les acteurs d'une société et qui façonnent les interactions entre eux.

*Ces règles et mécanismes peuvent être formels, inscrits dans des institutions et des lois ou informels et reflétés dans des schémas de comportement.*



**Application au contexte suisse ?**

# Governance

## Health System Actionable Governance

Mode

Actions

Design

Results

Strategizing

Participation & Voice

Intelligence

Agencies

Implementing

Laws & Regulations

State

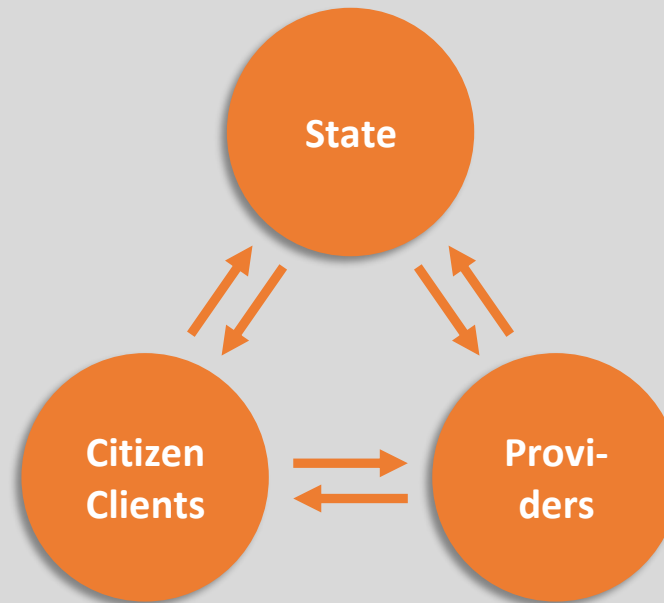
Citizen Clients

Providers

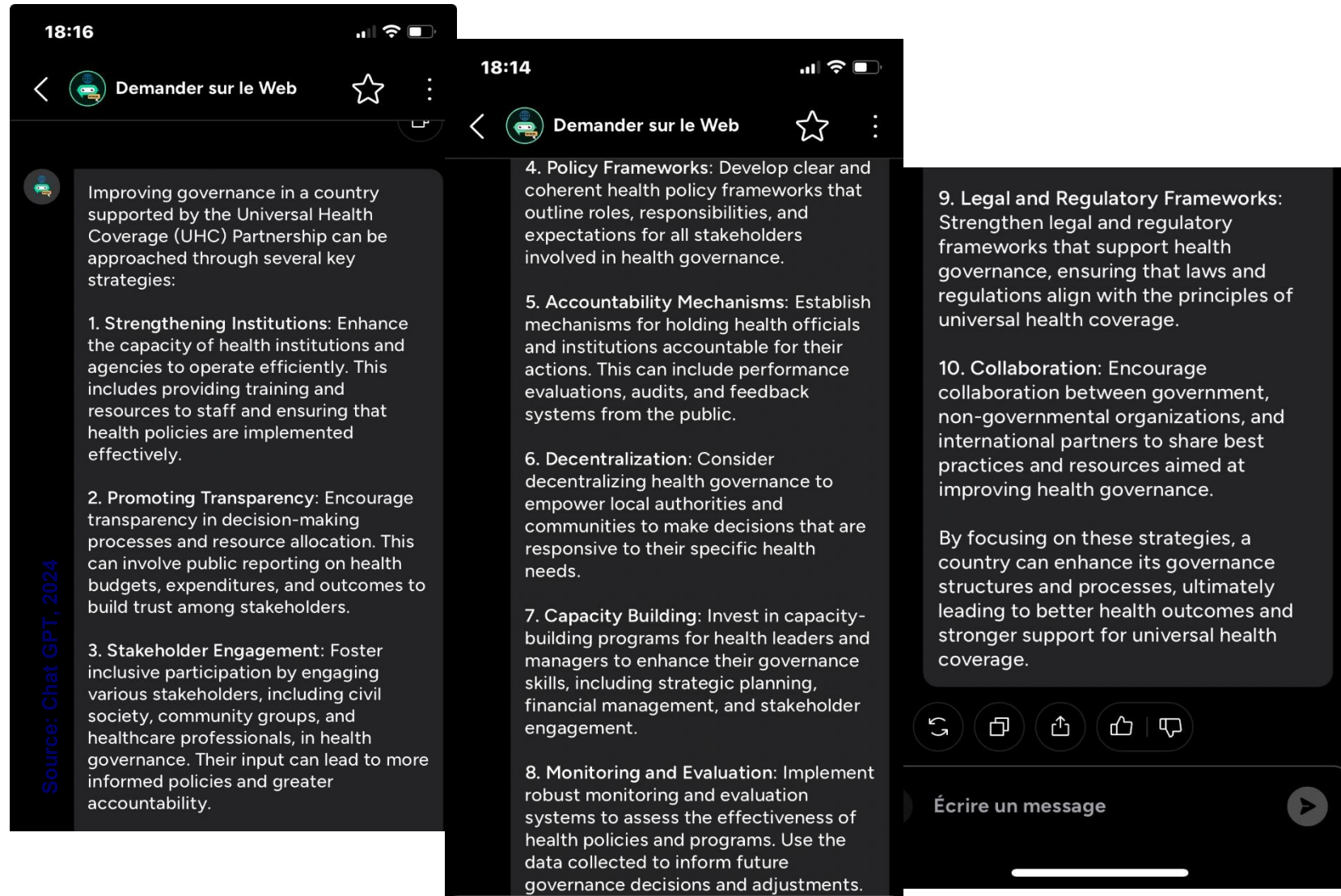
Empowerment

Accountability

Transparency



# Understanding governance from an operational perspective: the Universal Health Coverage Partnership...



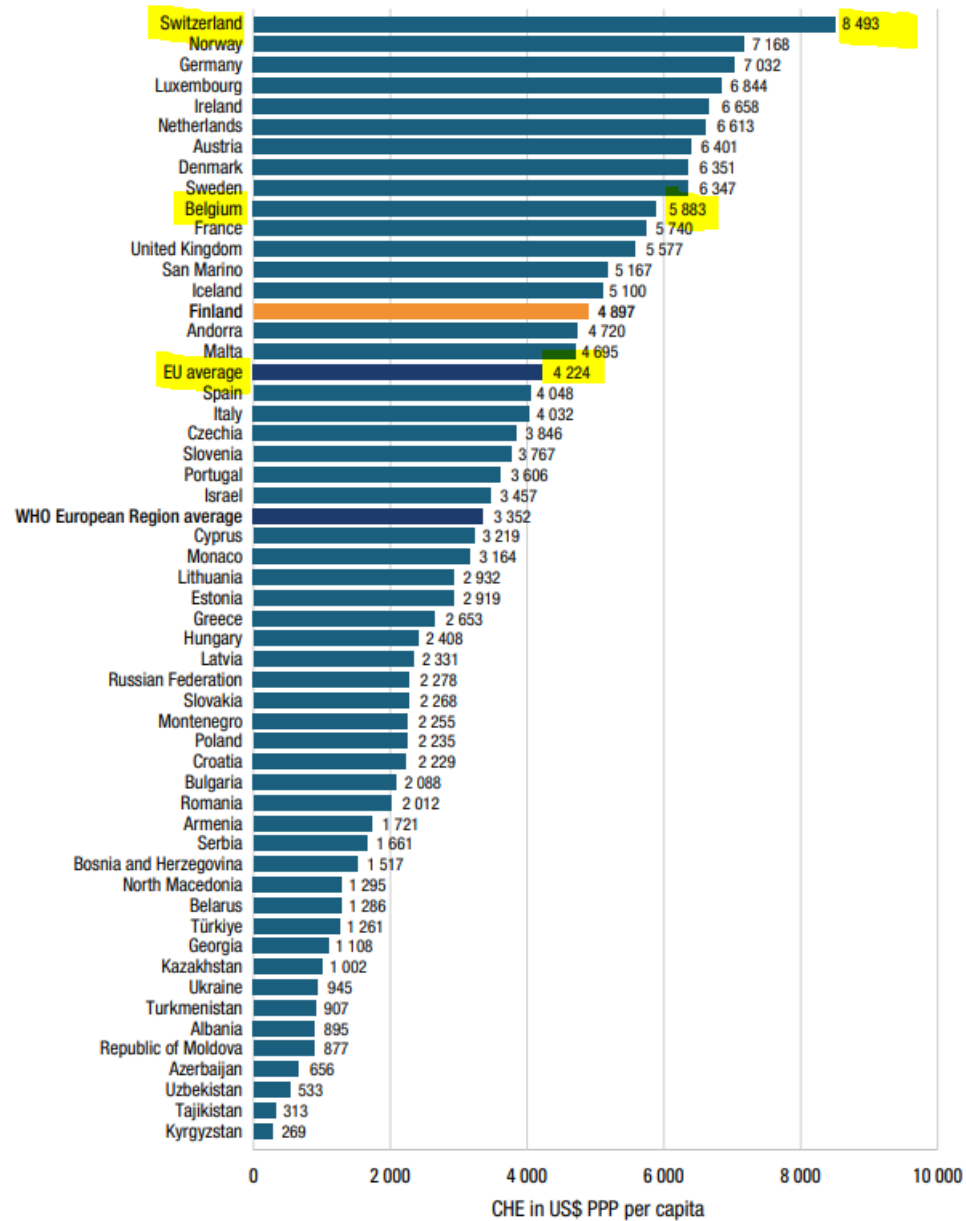
Source: Chat GPT, 2024



<https://extranet.who.int/uhcpartnership/>

**FIG. 2 CURRENT HEALTH EXPENDITURE (US\$ PPP) PER CAPITA IN WHO EUROPEAN REGION COUNTRIES, 2020**

**Notes:** CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity.  
**Source:** WHO Global Health Expenditure Database, 2022.

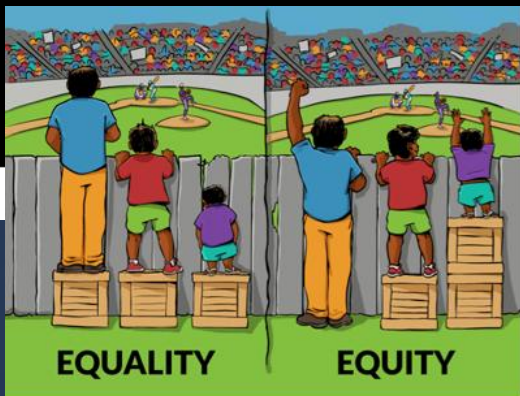


(Source: It's time to build a fairer, healthier world for everyone, everywhere.  
Health equity and its determinants. WHO – 2021)

## What is health equity?

**Health equity is the absence of unfair, avoidable and remediable differences in health status among groups of people.**

**Health equity is achieved when everyone can attain their full potential for health and well-being.**



*Then, what does «Justice» mean?*

**Between countries:** A child born in Lesotho can expect to live to the age of 51 while a child born in Japan can expect to live to 84. Under-5 mortality is more than eight times higher in Africa than in Europe, and developing countries account for 99% of the world's maternal deaths.

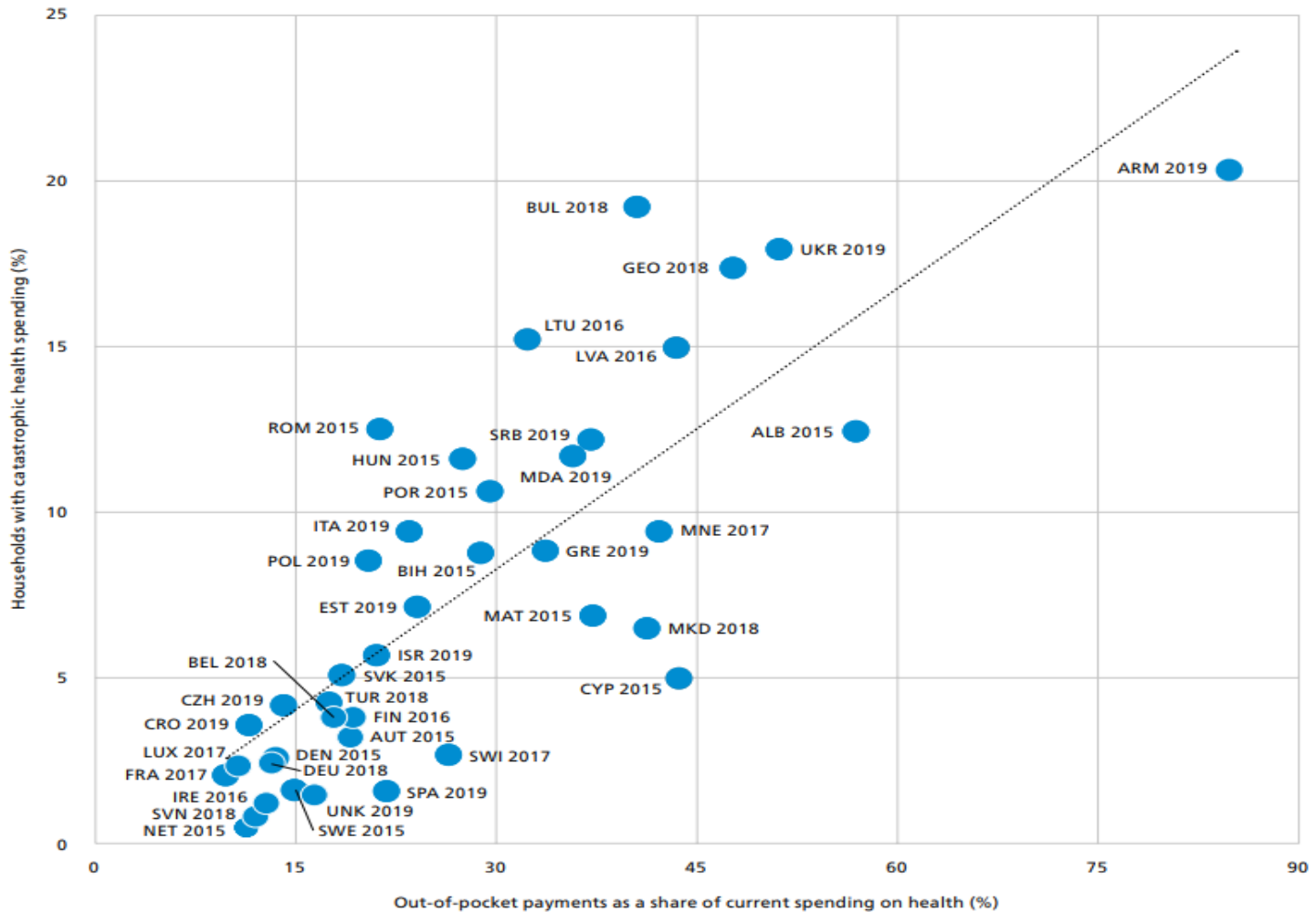
**Within countries:** Children from the poorest households are twice as likely to die before the age of 5 years than children from the richest households, while children in the poorest 20% of households are over four times more likely to experience severe mental health problems that those in the highest 20%.

**Between neighbourhoods:** In Glasgow, male life expectancy ranges from 66.2 years in less advantaged parts of the city to 81.7 years in more advantaged areas. In London, when travelling east from Westminster on the city's underground system, each stop represents a drop of nearly a year in life expectancy.

Fig. 16. Catastrophic health spending and out-of-pocket payments, 2019 or the latest available year before COVID-19

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year. See the note on Netherlands (Kingdom of the) in Fig. 3.

Source: data on catastrophic health spending: WHO Regional Office for Europe (2023a); data on out-of-pocket payments: WHO (2023).

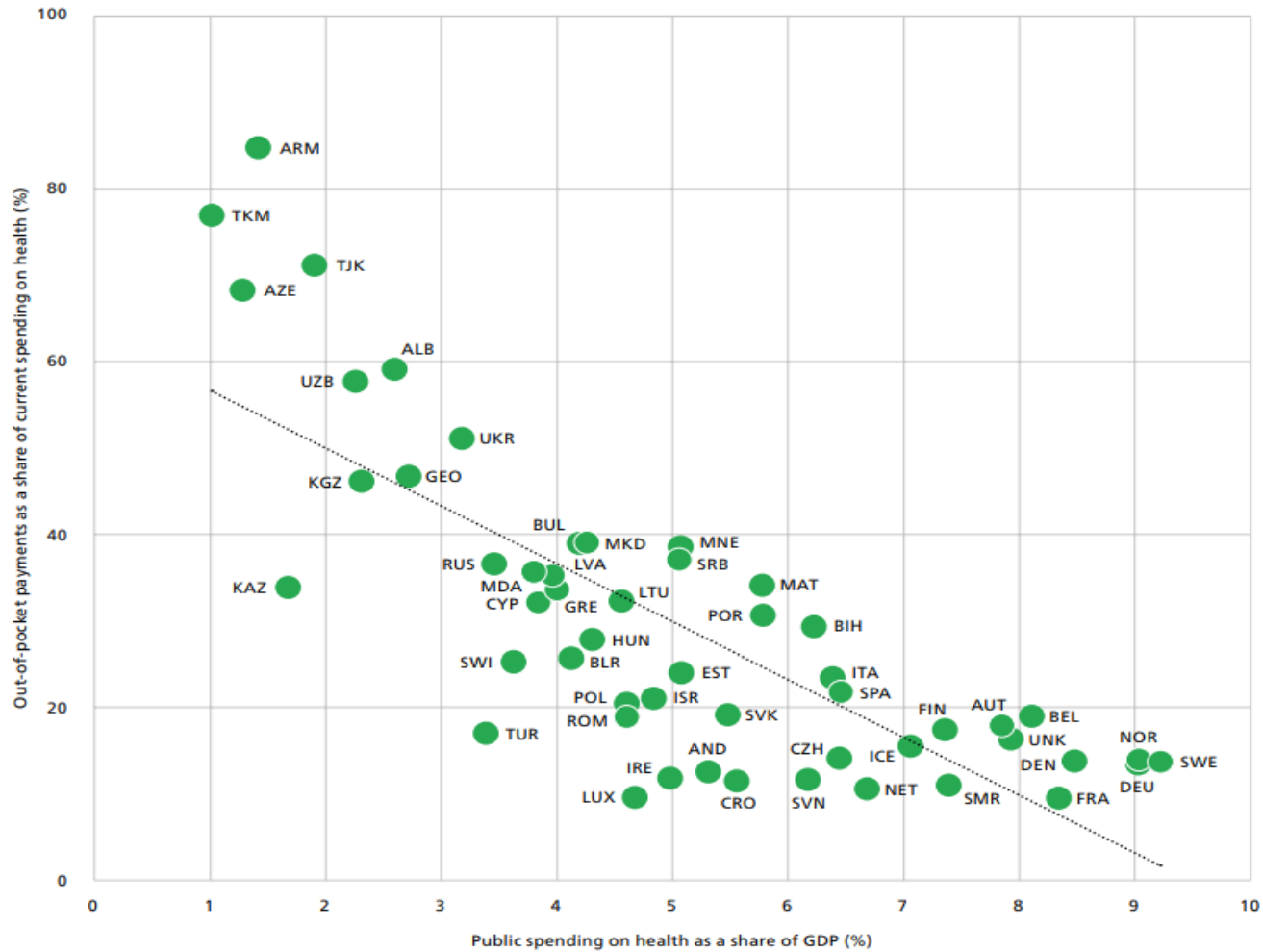


Source: Do people can afford to pay for health care? WHO EURO 2023

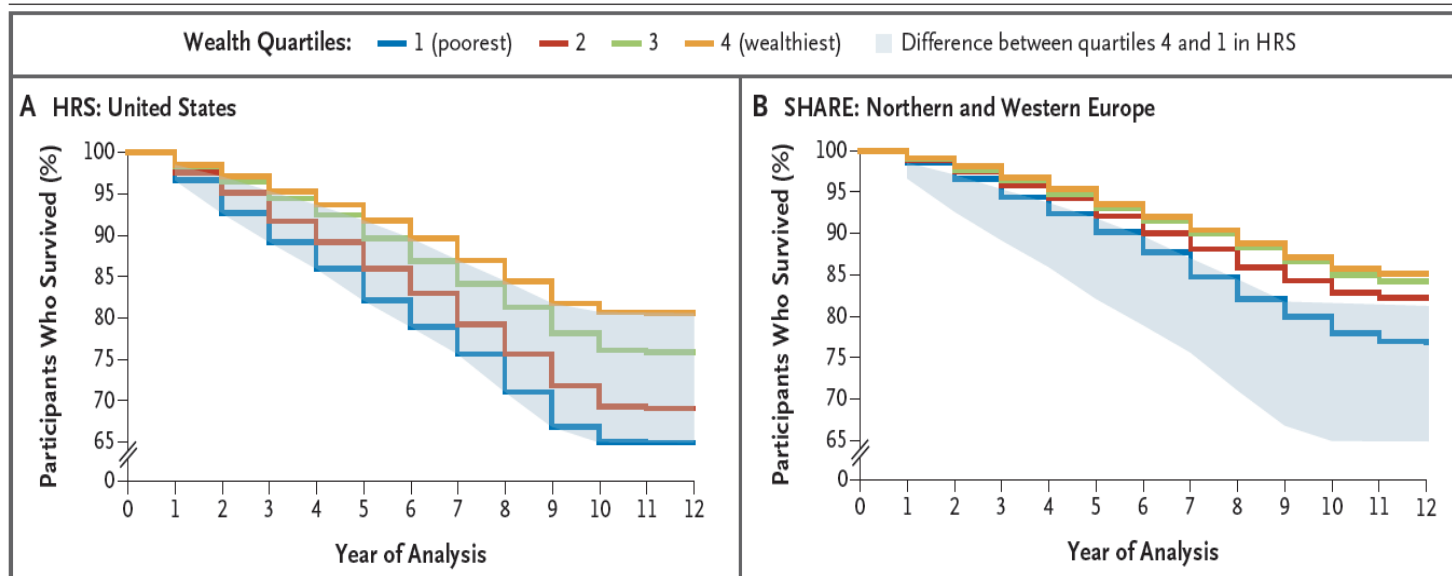
Fig. 17. Out-of-pocket payments and public spending on health, Europe, 2019

Notes: public spending on health is defined here as transfers from the government budget and social health insurance contributions. Out-of-pocket payment data for Albania are for 2014 (latest available data before 2019). The figure excludes Monaco.

Source: WHO (2023).



Source: Do people  
can afford to pay for  
health care? WHO  
EURO 2023



## Association between Wealth and Mortality in the United States and Europe

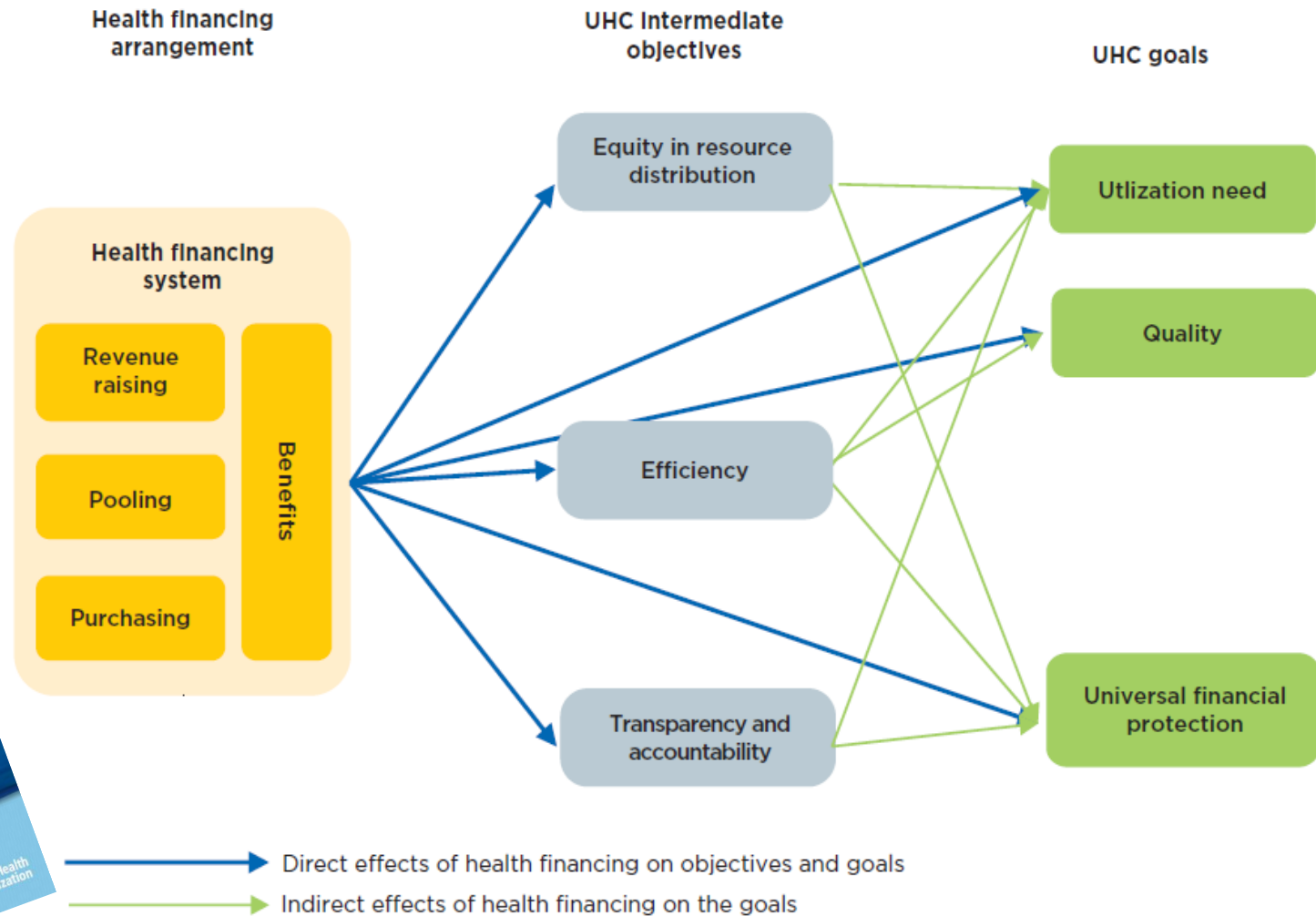
Sara Machado, Ph.D.,<sup>1,2</sup> Ilias Kyriopoulos, Ph.D.,<sup>2,3</sup> E. John Orav, Ph.D.,<sup>4,5</sup> and Irene Papanicolaou, Ph.D.<sup>1,3</sup>

N Engl J Med 2025;392:1310-9

- 1 We found that wealth was associated with mortality across the United States and Europe and that the difference in mortality between the top and bottom quartiles of wealth appeared to be larger in the United States than in Europe.
- 2
- 3 Mortality in the United States was higher than in Europe, even at higher wealth levels.

# L'OMS soutient les pays... l'exemple du financement de la santé

Fig. I.1. Intermediate objectives and final goals of UHC that health financing can influence



Source: Kutzin, J (2013). Health financing for universal coverage and health system performance: concepts and implications for policy; *Bulletin of the World Health Organization* 91:602-611. <https://www.who.int/bulletin/volumes/91/8/12-113985/en/>.

# We rely more on domestic resources...

- Les dépenses totales pour la santé augmentent plus que le PIB
- La proportion des paiements directs (OOP) décroît
- Au niveau Mondial, 1% seulement des dépenses de la santé provient de l'aide extérieure



An affordable necessity

# Both in rich and poor countries, universal health care brings huge benefits

The argument for universal health care is clear. But getting there is difficult,  
says John McDermott



AFP



Print edition | Special report >  
Apr 28th 2018

# Le système de santé en Suisse

Le système de santé est taillé sur mesures en fonction des héritages historiques et des orientations politiques des décideurs

La Confédération établit le cadre réglementaire et gère:

- l'assurance maladie obligatoire
- la lutte contre les maladies transmissibles
- la procréation médicalement assistée
- les transplantations, la recherche
- la formation des prestataires de santé
- le prix des médicaments
- les normes nationales de qualité et de sécurité des soins

Les cantons quant à eux appliquent la réglementation fédérale et ont des compétences étendues dans les domaines suivants:

- les soins hospitaliers
- la médecine de pointe
- l'exercice des professions de santé
- les initiatives de prévention sanitaire

# Discussion

Dans le contexte suisse, quelles sont les grandes mesures qui assurent la couverture sanitaire universelle ?

Est-ce que vous pensez que ces mesures sont satisfaisantes ?



**DE MANIÈRE PLUS CONCRETE...  
L'APPROCHE DES SOINS DE SANTÉ  
PRIMAIRES**



# Orientation politique sanitaire

En terme de prestations de services, l'orientation globale est celle des Soins de Santé Primaires

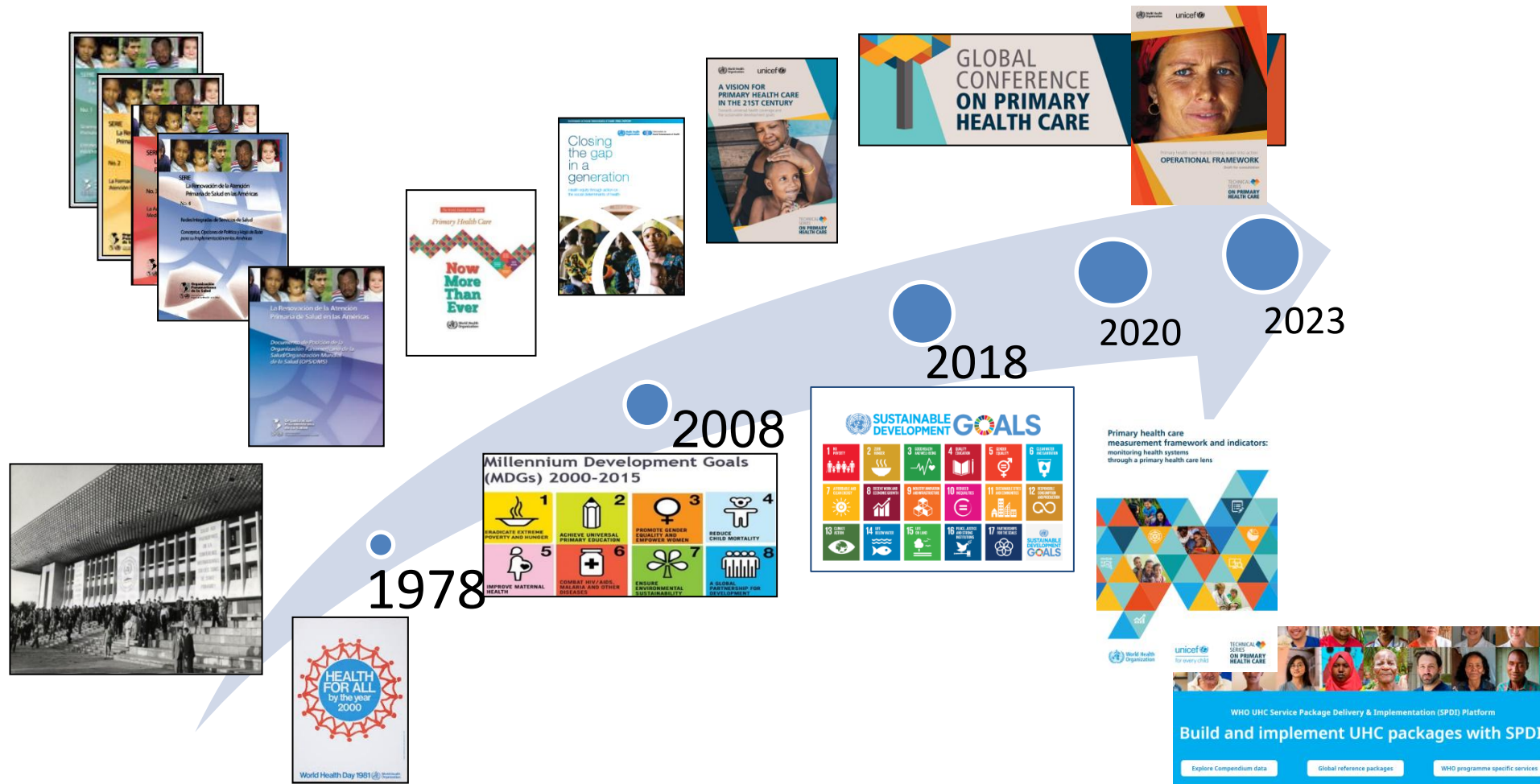


OECD Health Policy Studies

**Realising the Potential  
of Primary Health Care**



# From Alma Ata (1978) to Astana (2023): the long journey of PHC

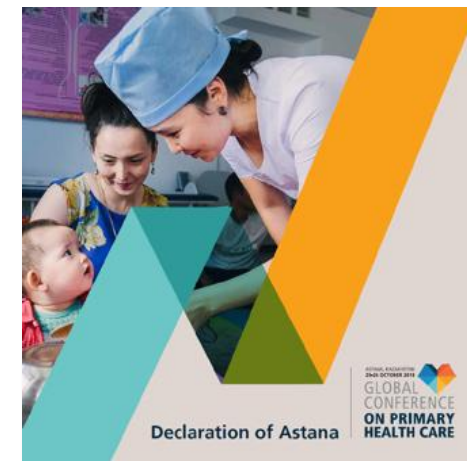


# What is Primary Health Care (PHC)?

PHC is a whole-of-society approach to health that aims to maximize the level and equitable distribution of health and well-being

- by focusing on people's needs (both as individuals and communities)
- as early as possible along the continuum of care
- as close as feasible to people's everyday environment

**PHC is an equalizer**

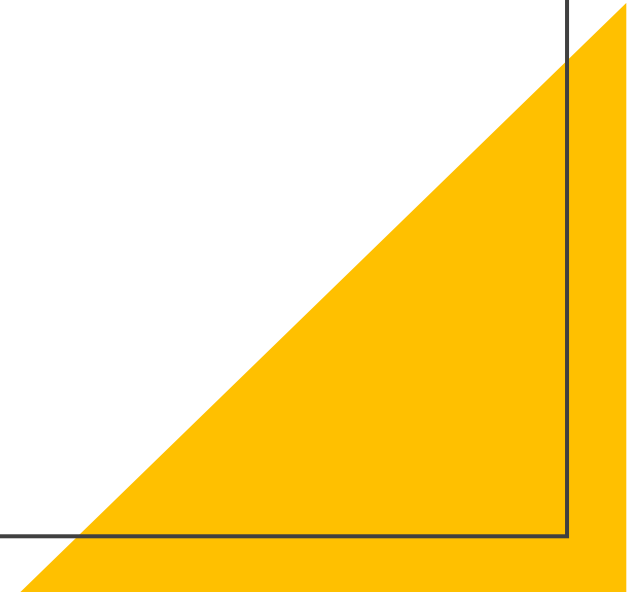
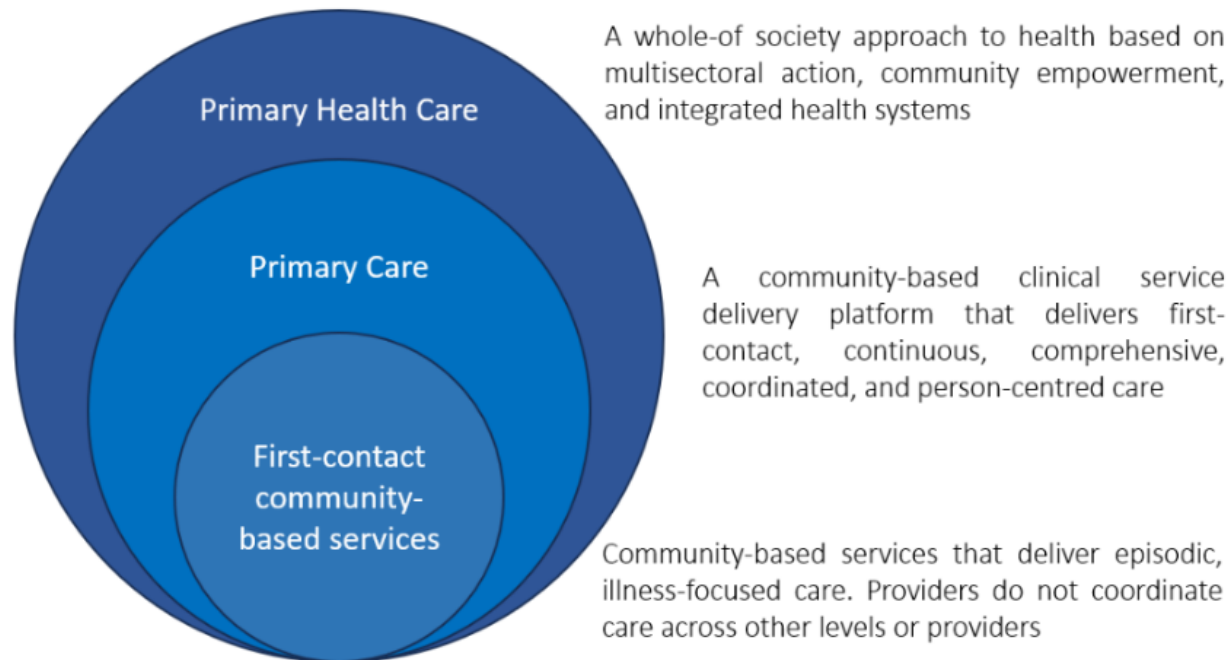


■ **Les soins de santé primaires (SSP) sont une approche** de la santé qui s'adresse à l'ensemble de la société et qui vise à maximiser le niveau et la répartition équitable de la santé et du bien-être en se concentrant sur les besoins et les préférences des personnes le plus tôt possible tout au long du continuum allant de la promotion de la santé et de la prévention des maladies au traitement, à la réadaptation et aux soins palliatifs.

■ **L'approche des soins de santé primaires accélère les progrès vers la couverture sanitaire universelle (CSU) et la sécurité sanitaire.** Dans le même temps, elle permet aux systèmes de santé de disposer de tous les services de santé essentiels, de grande qualité, accessibles et abordables pour les communautés, aussi près que possible de l'environnement quotidien des personnes.

■ **Les SSP combinent une politique et une action multisectorielles, un engagement communautaire et des services de haute qualité.** Elle intègre des interventions sanitaires au niveau de la population et de l'individu et fait passer les efforts d'une approche réactive de la maladie à une approche plus holistique et proactive de la santé et du bien-être.

Fig. 3. Three versions of PHC presented in the documents





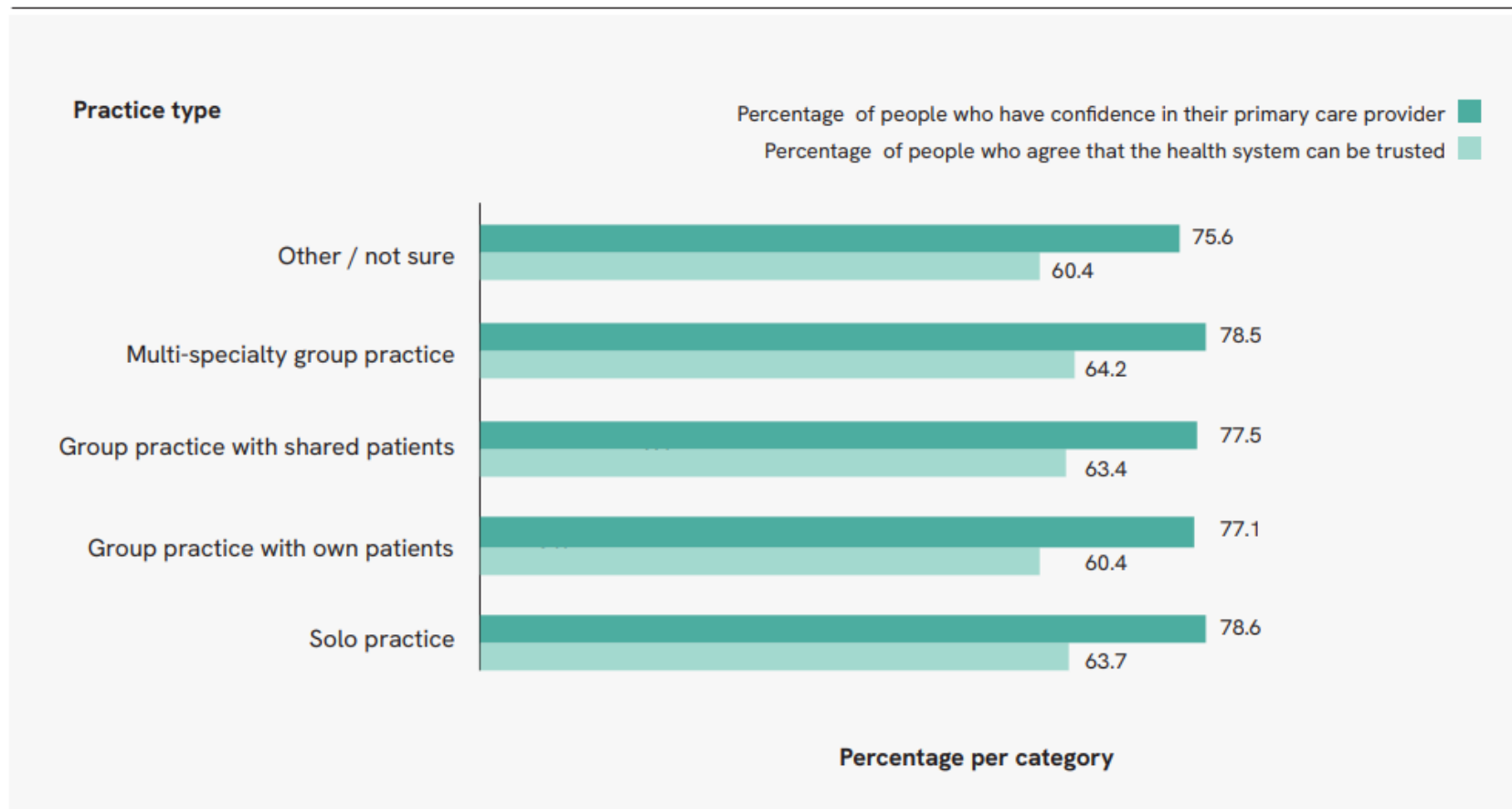
# VALUES

underpinning PHC have remained the same

---

- Health for all
- Solidarity
- Community orientation
- Social justice
- Equity
- People centredness

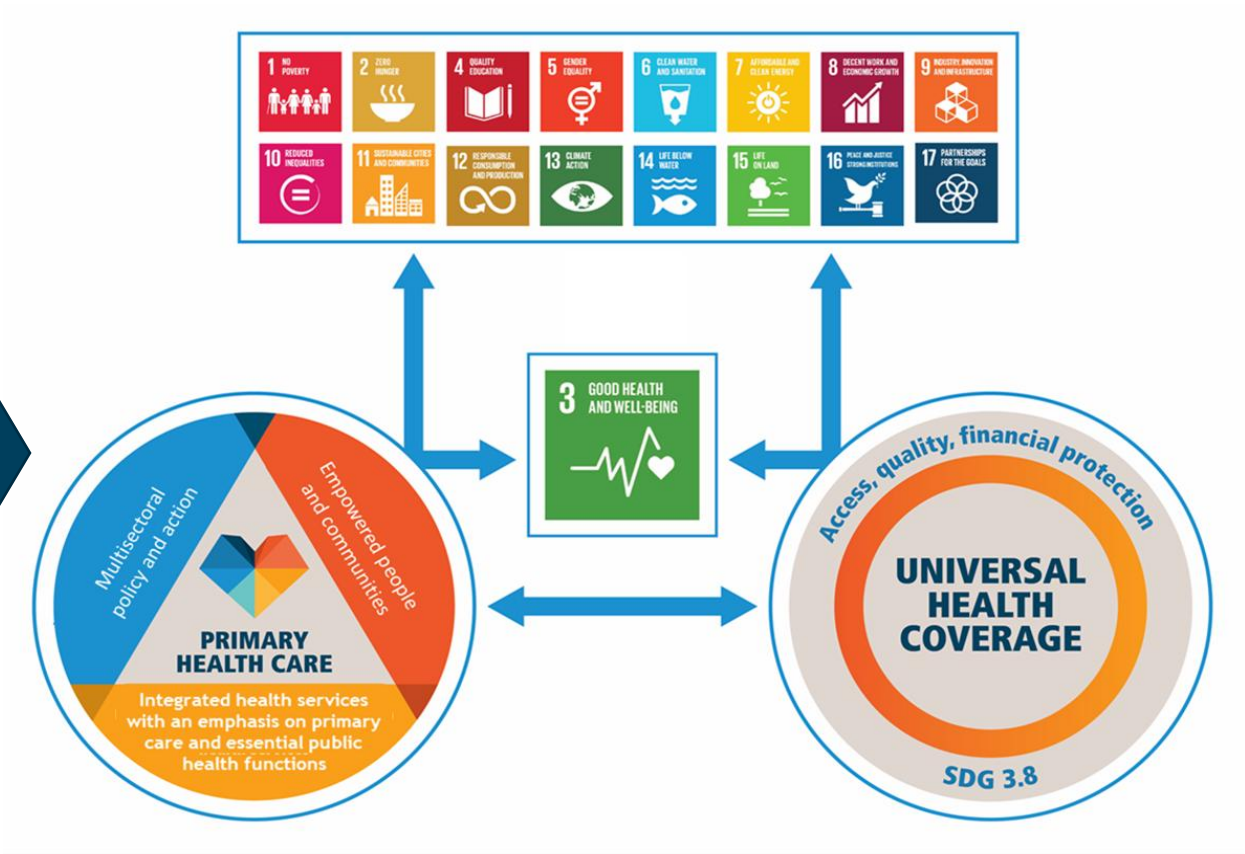
**FIGURE 7** | Trust in primary care providers is high, regardless of the way primary care delivery is organised



Source: Preliminary data PaRIS survey, 2023. [ is 61 126 patients in 1 218 primary care practices in 15 participating countries, incl. Belgium] - OECD

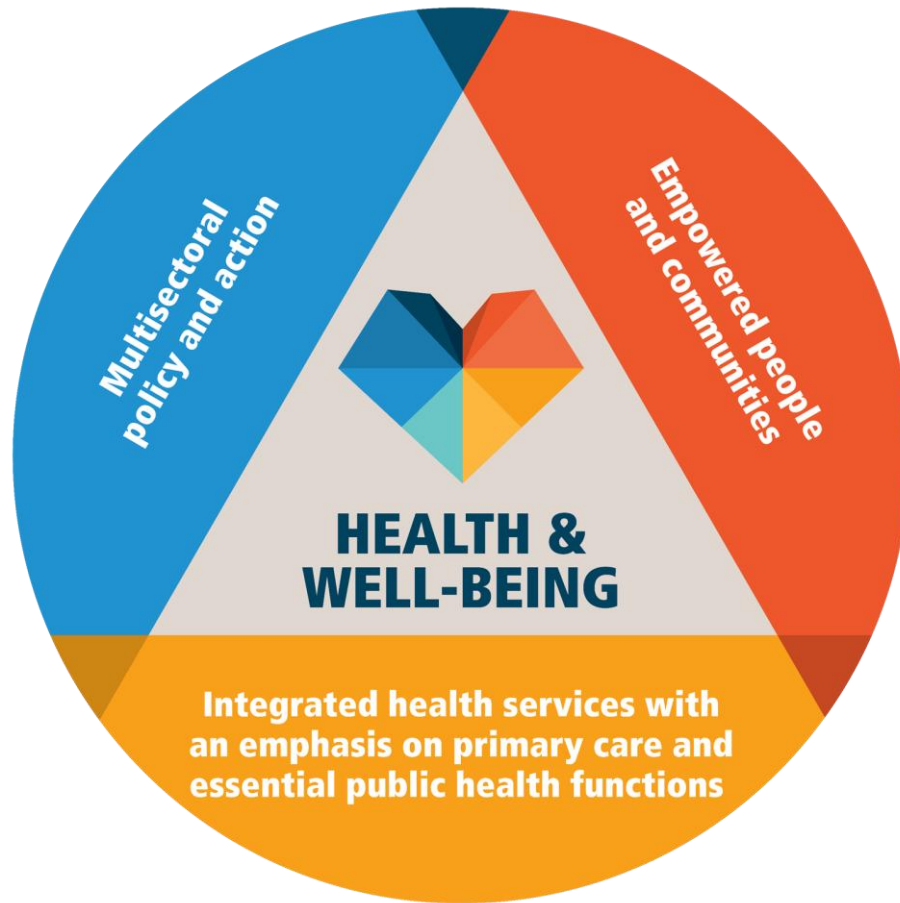
# PHC supports UHC and SDGs

- PHC is the **approach**  
 - Health systems are the **means**  
 - UHC and the health-related SDGs are the **goals**



Source: World Health Organization & United Nations Children’s Fund (UNICEF). (2018). A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. World Health Organization. <https://apps.who.int/iris/handle/10665/328065>. License: CC BY-NC-SA 3.0 IGO

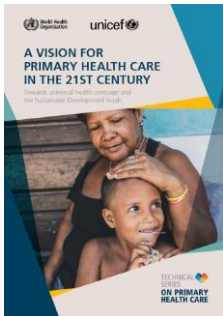
# Three components of primary health care



Multisectorality

Empowerment

Services



**Source:** World Health Organization & United Nations Children’s Fund (UNICEF). (2018). A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. World Health Organization. <https://apps.who.int/iris/handle/10665/328065>. License: CC BY-NC-SA 3.0 IGO

# Driving PHC Action: WHO UNICEF Operational Framework

A clear PHC theory of change linking the approach, levers for actions and results.







[Operational Framework for Primary Health Care \(who.int\)](https://www.who.int/publications/m/item/operational-framework-for-primary-health-care)




- Outlines 14 levers needed to translate commitment into actions and interventions
- Can be used to accelerate progress into strengthening PHC-oriented systems
- Levers are interdependent and impact and enable each other



# The effect of primary healthcare on mortality: Evidence from Costa Rica ☆

[Claudio A. Mora-García](#)<sup>a</sup>  , [Madeline Pesec](#)<sup>b</sup> , [Andrea M. Prado](#)<sup>c</sup> 

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<https://doi.org/10.1016/j.jhealeco.2023.102833> 

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## Abstract

This paper uses the gradual implementation of a primary healthcare (PHC) intervention in Costa Rica to examine the long-term effect of PHC on mortality. Nine years after opening a primary care center, known as a Health Area, there was an associated 13% reduction in age-adjusted mortality rate in the assigned patient population. The effect was highest among adults over 65 years of age and for those with noncommunicable diseases, such as cardiovascular-related causes of death. We also show that as Health Areas opened, more individuals sought care at primary care clinics, while fewer sought care at emergency rooms; these changes may have partially mediated the effect of the intervention on mortality.

RESEARCH ARTICLE

Open Access

Impacts of multimorbidity on medication treatment, primary healthcare and hospitalization among middle-aged and older adults in China: evidence from a nationwide longitudinal study



*(...) Therefore, a strong primary care system led by a mix-skilled healthcare professional team is essential for delivering integrated care for people with multimorbidity [11, 12, 36].*

World Health Report 2008. Primary Health Care - Now More Than Ever  
WHO, 2008

RESEARCH

Open Access



# Strengthening primary health care resilience through community innovation: a qualitative case study from Quito's response to COVID-19

Betzabé Tello<sup>1\*</sup>, Iván Dueñas-Espín<sup>2</sup> and Laura Di Giorgio<sup>3</sup>

**Abstract**

**Background** This study aimed to analyse and document how Quito, the capital city of Ecuador, transformed its Primary Health Care (PHC) model following the COVID-19 pandemic. The reform involved a shift from a reactive, hospital-centred response to a community-based model focused on prevention, social determinants of health, and local engagement.

**Methods** This study used a qualitative case study design with a comparative and deductive approach, featuring 11 semi-structured interviews with health professionals, decision-makers, and administrative staff, alongside a review of secondary sources, including municipal legal framework (such as the Organic Code and the municipal Organic Statute), ordinances, and governance documents and accountability reports from three mayoral administrations. The study factors and compared Quito's experience with other cities in Ecuador and I



**Results** The central innovation was the creation of multidisciplinary Community Health Teams (Equipos de Salud Comunitaria, ESC) assigned to each of Quito's 65 parishes. These teams focused on health promotion, disease prevention, and intersectoral coordination. Their implementation was supported by continuous training, integration of digital tools, community-based communication strategies, and protocols for operating in high-risk environments. A major driver of the reform was the political negotiation to sustain the increased health budget beyond the pandemic, enabling the long-term operation of ESCs. Ensuring the physical safety of health personnel also became a core component of the model, supported by risk mapping, emergency communication systems, and coordination with local security actors. The model was institutionalized through legal frameworks and aligned with national initiatives such as the Healthy Municipalities Programme and Comprehensive Family, Community and Intercultural Health Care Model (MAIS-FCI). The model demonstrated improved territorial access, community trust, and responsiveness amid rising urban violence, but faces limitations in technological infrastructure, monitoring indicators, and long-term sustainability.

# Un exemple d'intégration en Italie...

## Physiotherapy as part of primary health care, Italy

Alessandra Da Ros,<sup>a</sup> Matteo Paci,<sup>b</sup> Elisa Buonandi,<sup>b</sup> Laura Rosiello,<sup>b</sup> Sandra Moretti<sup>b</sup> & Chiara Barchielli<sup>a</sup>

**Objective** To describe the Family and Community Physiotherapist model, which aims to incorporate rehabilitation services within primary health care in Tuscany, Italy.

**Methods** The Department of Health Professions of the Central Tuscany local health authority designed the model during 2020–2021. We describe the four phases of the organizational case study implementation of the model, namely: (i) analysis of the political and organizational framework, as well as determination of changing health-care needs; (ii) model co-design and training of multiprofessional health-care workers (local general practitioners, physiatrists and geriatricians); (iii) delivery and surveillance of rehabilitation services; and (iv) evaluation.

**Findings** During the initial roll-out of the project in April–December 2021, general practitioners referred 165 patients with a mean age of 83.7 years (standard deviation: 11.1) to the Family and Community Physiotherapist. Interventions were mainly activated for patients with comorbidities (64/165; 38.8%), followed by those with long-term immobilization issues (36/165; 21.8%). The most commonly provided intervention was counselling, contributing to the achievement of objectives for 127 patients (77.0%). A full rehabilitation path was proposed for only 10 patients (6.1%). No additional costs were incurred by the health authority during the implementation of the model.

**Conclusion** Our model facilitated the provision of rehabilitative care in the community, preventing the exacerbation of chronic conditions and meeting the population health needs in non-hospital environments. The model overcame the typical lack of integration within health-care services with flexibility, promoting care proximity solutions to cope with health challenges such as an ageing population and the prevalence of chronic diseases.

Source: Da Ros *et al*, Bulletin of the WHO, Nov. 2022 pp669-675

# The Turkish example... 1/3

## Vision

A TURKEY where healthy lifestyles are embraced and everyone can easily exercise their right to health

## Mission

To maximise the protection of individual and community health with a human-centred approach and to offer timely, appropriate and effective solutions to health problems

## Ultimate Goal:

To protect and improve the health of our people in an equitable manner

## Strategic Goal 1

To protect the individual and the community from health risks and foster healthy life styles

## Strategic Goal 2

To provide accessible, appropriate, effective, and efficient health services to individuals and the community

## Strategic Goal 3

To respond to the health needs and expectations of individuals based on a human-centred and holistic approach

## Strategic Goal 4

To continue to develop the health system as a means to contributing to the economic and social development of Turkey and to global health

## The history...

- Panel 2: Towards universal health coverage: key developments in the HTP, 2003-12
- 2002: Justice and Development Party includes "improving access to health services" (urgent action plan) in its election platform.
  - 2002: Justice and Development Party is elected with a strong parliamentary majority in the Grand National Assembly.
  - 2002: Ministry of Health Decree (on the first day of the new government) to eliminate involuntary incarceration in hospitals of patients who cannot meet health-care expenses. The decree forbids hospitals from withdrawing the bodies of deceased patients when families are unable to meet hospital expenses.
  - 2002: The Health Transformation Program (HTP) is designed, building on work done in the previous decade, including element of the Basic Health Law implementation of the HTP begins.
  - 2003: Introduction of higher salaries and performance incentives for hospital clinicians to encourage voluntary transitions to full-time working. Major incentives for hospital clinicians to encourage voluntary transitions in 2005.
  - 2003-04: Active and retired civil servants are allowed to use private hospitals. Ambulance services expanded to include outpatient benefits and pharmaceuticals. Conditional cash transfers were reintroduced, covering 5% of the population (for pregnant women and children from the most disadvantaged households), to encourage use of maternal, neonatal, and child health services.
  - 2004: Contract-based employment introduced for health-care personnel in rural and less developed regions. Performance-based payments piloted in ten Ministry of Health hospitals.
  - 2004: Major changes in pharmaceutical policy, including reference price system introduced, replacing the cost-plus changes to pricing and to value-added tax. International model to reduce the price of drugs.
  - 2004: Patient Rights Directive established in hospitals implemented. Patient rights limits established in hospitals. Electronic systems for patient complaints and suggestions introduced.
  - 2004: User choice of health-care providers (hospitals, primary care centres, and physicians) introduced.
  - 2005: Hospitals belonging to the Social Security Organisation (16 hospitals) integrated with Ministry of Health hospitals. The total number of hospitals managed by the Ministry of Health reached 5,419 in 2011.
  - 2005: Contract-based family medicine in Düzce province.
  - 2005: Contract-based contracting piloted in Düzce province.
  - 2006: Universal health insurance is legally adopted as a part of broader social security reform. Health expenditures start to grow and global budgets (budget ceilings) are introduced for Ministry of Health facilities to moderate growth in services to address unmet need.
  - 2006-10: Contract-based family medicine scaled up in all 81 provinces of Turkey.
  - 2007: Cost sharing for primary health-care services abolished. Primary health care available for all citizens free at the point of delivery.
  - 2008: Social Security Institution established as a single organisation for financial pooling and purchasing. The Social Insurance Organisation, Bağ-Kur, and the General Employees Retirement Fund join the Social Security Institution.
  - 2008: Free availability of emergency services and intensive care services (including neonatal intensive care) for all whole population extended from public hospitals to all hospitals, including private hospitals with and without Social Security Institution contracts.
  - 2008: National air ambulance service introduced and is available to the whole population free of charge. Major expansion in 2010.
  - 2008: Cost-sharing in private hospitals for complex conditions (eg, tumors, renal dialysis, congenital anomalies, cancer, cardiovascular surgery, and transplant surgery) abolished.
  - 2009: Mobile pharmacy services introduced to improve access in rural areas.
  - 2009: Tracking system for drugs introduced.
  - 2009: Central hospital patient appointment system introduced. Major expansion in 2012.
  - 2010: Active civil servants join the Social Security Institution.
  - 2010: The Ministry of Health strategic plan for 2010-14 developed.
  - 2010-11: Taxes for cigarettes and alcohol raised.
  - 2010-12: Laws on Hospital Authority and Restructuring the Ministry of Health for a stronger stewardship function are adopted. Public Hospital Authority and Public Health Institution established. Law on Full-Time Practice of University and Health Personnel and Amendments is adopted, paving the way for full-time practice in legal terms.
  - 2012: The Green Card scheme joins the Social Security Institution and unified social health insurance is fully implemented.
  - 2013: The Ministry of Health strategic plan for 2013-17 is developed.

2012: The Green Card scheme joins the Social Security Institution and unified social health insurance is fully implemented.

2013: The Ministry of Health strategic plan for 2013-17 is developed.

The fiscal space created by sustained economic growth in Turkey enabled the government to substantially increase health expenditures. From 2003, total health expenditures as a proportion of GDP increased from 5.3% to reach 6.1% in 2008, with almost three-quarters of this amount coming from the public sector. Private sector investment in the health sector also rose.

2005: Contract-based family medicine with performance-based contracting piloted in Düzce province.  
2006-10: Contract-based family medicine scaled up in all 81 provinces of Turkey.

The findings from the controlled before and after study undertaken as part of this study (appendix pp 2-13), which explored services provided by primary health-care physicians before (phase 1) and after (phase 2) the introduction of the new family medicine model, showed substantial improvements in the availability of key maternal and child health services after the introduction of the model. The immunisation services provided on a daily basis by the primary care physicians surveyed increased from 60.6% in phase 1 to 91.4% in phase 2.

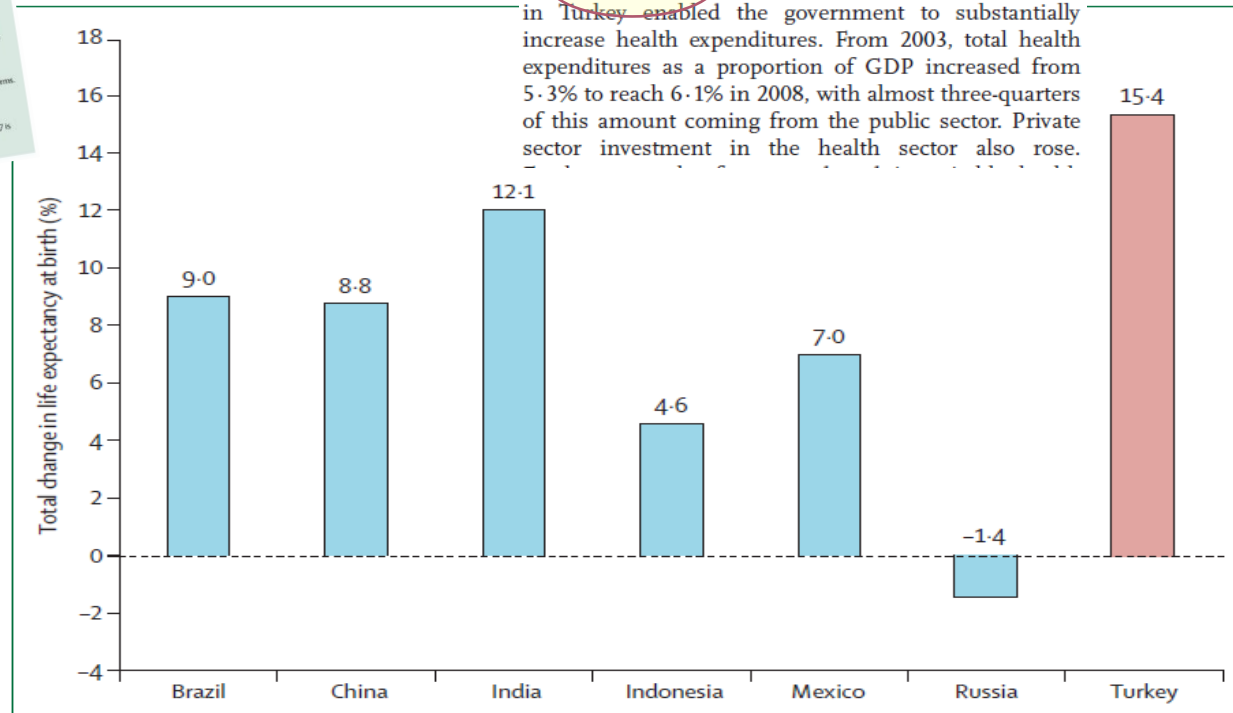
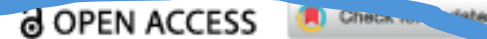


Figure 3: Percentage change in life expectancy at birth (years) in Brazil, China, India, Indonesia, Mexico, Russia, and Turkey, 1990-2009. Data are from reference 14.

# Résultats

- Augmentation de l'espérance de vie
- Séparation de la fonction de "stewardship", financement et prestation des services
- Rôle du MS renforcé pour ce qui concerne le développement des politiques, l'information (intelligence), redevabilité (citoyens) et la coordination intersectorielle
- Le plan de développement sanitaire est accompagné d'un rapport de situation annuel, d'un rapport à mi parcours (2015) et d'un rapport final en 2018

RESEARCH ARTICLE



## Strengthening Primary Health Care in Europe: A Delphi study towards accessibility, equity and continuity of care

Ileana Gefaell Larrondo<sup>a,b,c,d</sup> , Sara Are José Joaquín Mira<sup>f</sup>, Clara Pérez Esteve<sup>g</sup>, Milena Kostić<sup>j</sup>, Achim Mortsiefer<sup>k</sup>, Ferdin Pilar Astier-Peña<sup>n</sup> 

<sup>a</sup>Federica Montseny Health Centre, Gerencia Asistencial; <sup>b</sup>Unidad de Investigación, Gerencia Asistencial de Ate Gregorio Marañón, Madrid, Spain; <sup>c</sup>European General Investigation Support Multidisciplinary Unit for Prima Atención Primaria, Servicio Madrileño de Salud, Madrid Joan Health District. Alicante, Spain. Conselleria de Sar Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel; <sup>d</sup>Research, Sciensano, Brussels, Belgium; <sup>e</sup>MD. Health Cen General Practice, Medical Faculty, Heinrich-Heine-Univer. Patient-Centredness in Primary Care, Institute of General University, Witten, Germany; <sup>f</sup>Department of Clinical Scie University, Malmö, Sweden; <sup>g</sup>CHNP, Rehaklinik, Ettelbruck for Health and Behaviour. Department of Behavioural an Sciences, Luxembourg University, Luxembourg; <sup>h</sup>University Service of Aragon (Spain). Grupo H26\_3D-IIS-Aragón. Pres

### KEY MESSAGES

- There is strong consensus on the importance of PHC across Europe, yet participants perceive
- Stronger policy prioritisation is essential to make sustainable.

### ABSTRACT

**Introduction:** Strengthening Primary Health Care (PHC) is essential for building resilient and equitable health systems, but PHC faces barriers in implementation, resource allocation, and political prioritisation. This study aimed to develop a strategic roadmap to enhance PHC by identifying core values, priorities, and actionable strategies through expert consensus.

**Methods:** A two-round Delphi study was conducted with 210 stakeholders from 35 countries, including PHC professionals, policymakers, and public health experts. Participants evaluated the importance, feasibility, and policy prioritisation of key PHC values. Quantitative data were analysed using descriptive statistics.

**Results:** The response rate was 81.4% (171/210) in round one and 73.5% (97/132) in round two. The majority of participants (89%) had a background in medicine. A consensus (>80% agreement) was reached in the first round regarding PHC values. Key recommendations included increasing investment in PHC workforce development, particularly in underserved areas; strengthening health information systems and integrating telehealth solutions; enhancing PHC governance models to support multidisciplinary collaboration and citizen-centred care; and adapting processes to improve chronic care management, end-of-life support, and standardised assessment frameworks. In the second round, when participants assessed the feasibility of these recommendations, agreement levels ranged from 61 to 92%. When asked about the policy prioritisation of these measures, agreement dropped, ranging from 22 to 51%.

# Implementing the primary health care approach

## A primer



Dheepa Rajan  
Katherine Rouleau  
Juliane Winkelmann  
Melitta Jakab  
Dionne Kringos  
Faraz Khalid

CONFERENCE  
COPY

GLOBAL REPORT  
ON PRIMARY  
HEALTH CARE



World Health  
Organization



[Ctrl+Click here: Primary Health Care \(who.int\)](https://www.who.int)

See Chapter one and the glossary

NB: pour la traduction vous pouvez utiliser DeepL



18 July 2022

How can skill-mix innovations support the implementation of integrated care for people with chronic conditions...



19 April 2022

Health system performance assessment: a framework for policy analysis



GOBIERNO DE ESPAÑA  
M D  
**Transforming Primary Health Care: from Spain to Europe**  
11 March 2024 10:30 – 18:00 CET



**Ensuring health security: how primary health care can strengthen resilience**  
21 November 2023 12:00 – 13:00 CET

**More information on PHC in Europe: ctrl+click the link below!**

[Primary Health Care \(who.int\)](https://www.who.int/europe/primary-health-care)

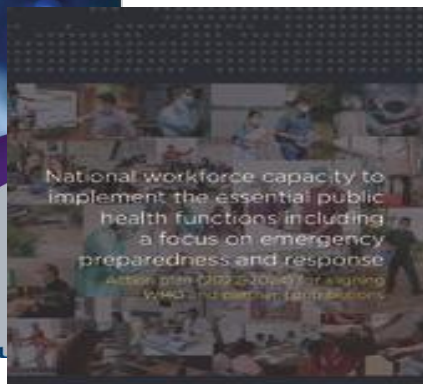
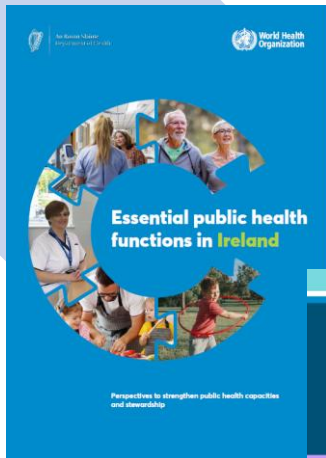


Pause -  
Questions



Est-ce vraiment aussi simple ?

# Application of Essential Public Health Functions (EPHF)



## A consolidated list of EPHFs

1. **Public health intelligence:** monitoring and evaluating population health status, health service utilization and surveillance of risk factors and threats to health
2. **Public health emergency management:** managing public health emergency
3. **Public health governance:** assuring effective public health governance, regulation, and legislation
4. **Public health planning and financing:** supporting efficient and effective health systems and multisectoral planning, financing and management for population health
5. **Health protection:** protecting populations against health threats, including environment and occupational hazards, communicable disease threats, food safety, chemical and radiation hazards
6. **Disease prevention and early detection:** promoting prevention and early detection of diseases (communicable and noncommunicable)
7. **Health promotion:** Promoting health and well-being and actions to address the wider determinants of health and inequity
8. **Community participation:** Ensuring community engagement, participation and social mobilization for health and well-being
9. **Public health workforce:** Ensuring adequate quantity and quality of public health workforce
10. **Health services quality and equity:** Assuring quality of and access to health services
11. **Public health knowledge and research:** Advancing public health research
12. **Use of and access to medical products:** Ensuring equitable access to and rational use of essential medicines and other health technologies

[21st century health challenges: can the essential public health functions make a difference?: discussion paper \(who.int\)](#)



## Combatting current and future health threats



As we shift the focus on what to do, an **equally fundamental shift** must occur on **how** to do it. A new global health order is emerging—and the EU must contribute to shaping it through a more strategic and effective engagement.

The EU has a unique potential to drive international cooperation. **Expanding partnerships** with a wide range of relevant stakeholders is of the utmost importance—promoting **health sovereignty for more resilience and open strategic autonomy** supported by partners' political commitment and responsibility. Our relationship with international partners must be guided by common priorities in line with this strategy.

## *The BeOH Coordination Team*

---

The BeOH Coordination Team was created in 2023 to support the network's activities. Since its inception it has provided inputs for the BeOH's vision and missions, the update of the BeOH website, and the organisation of the BeOH events.





# Welcome

Founded jointly by the Vetsuisse Faculty, the Faculty of Medicine and the Faculty of Science, the One Health Institute (OHI) has been established as a new institute at the University of Zurich in May 2023.

In 2019, the UZH designated One Health as one of its strategic research foci. A multi-year start-up funding, the TRANSFORM funding line, allowed launching of the OHI initiative now set to fill this strategic focus with life, and to grow thematically, eventually including more faculties within the next few years.

Fig. 2.1. Climate change risks to health and health systems, and outcomes

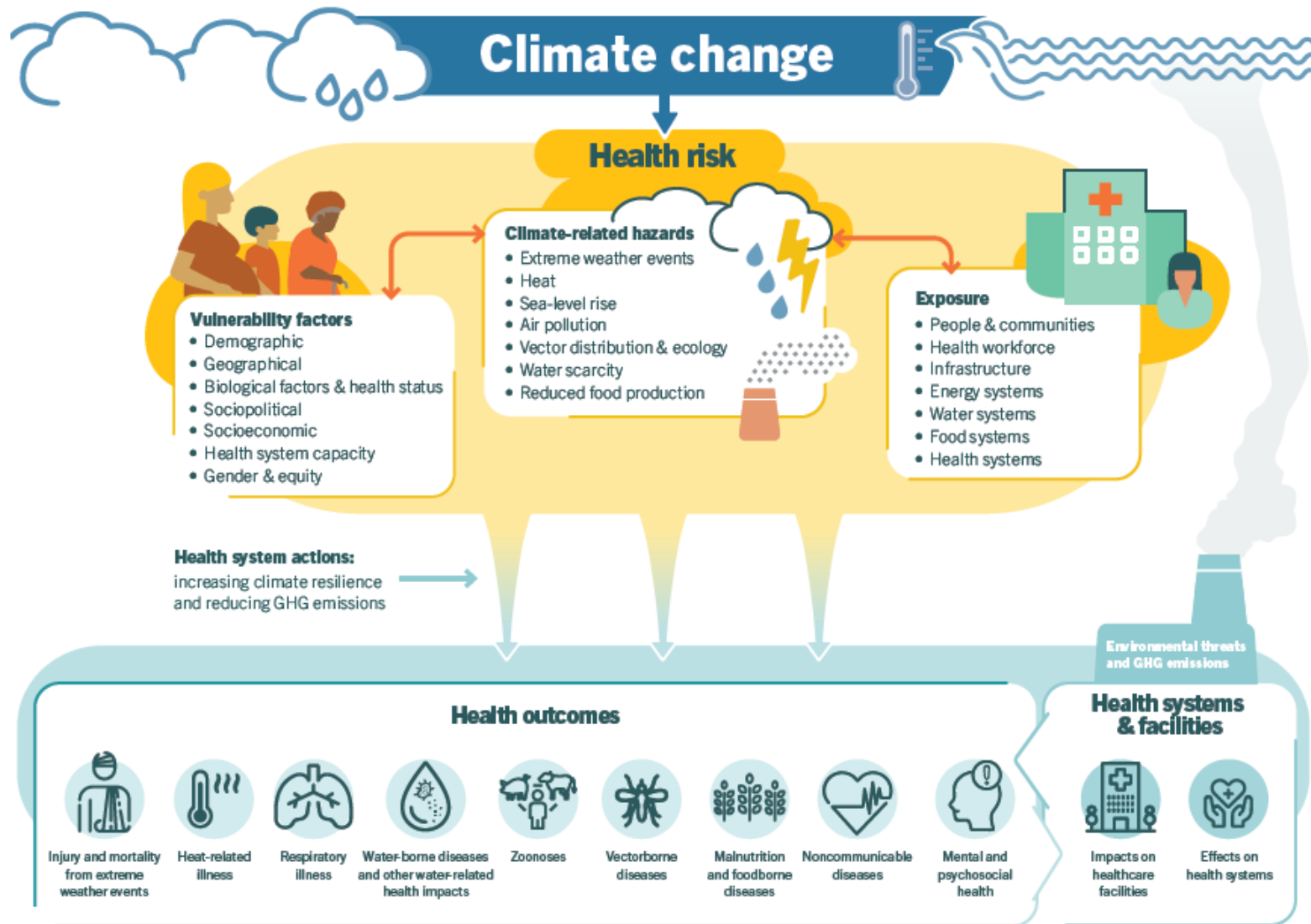
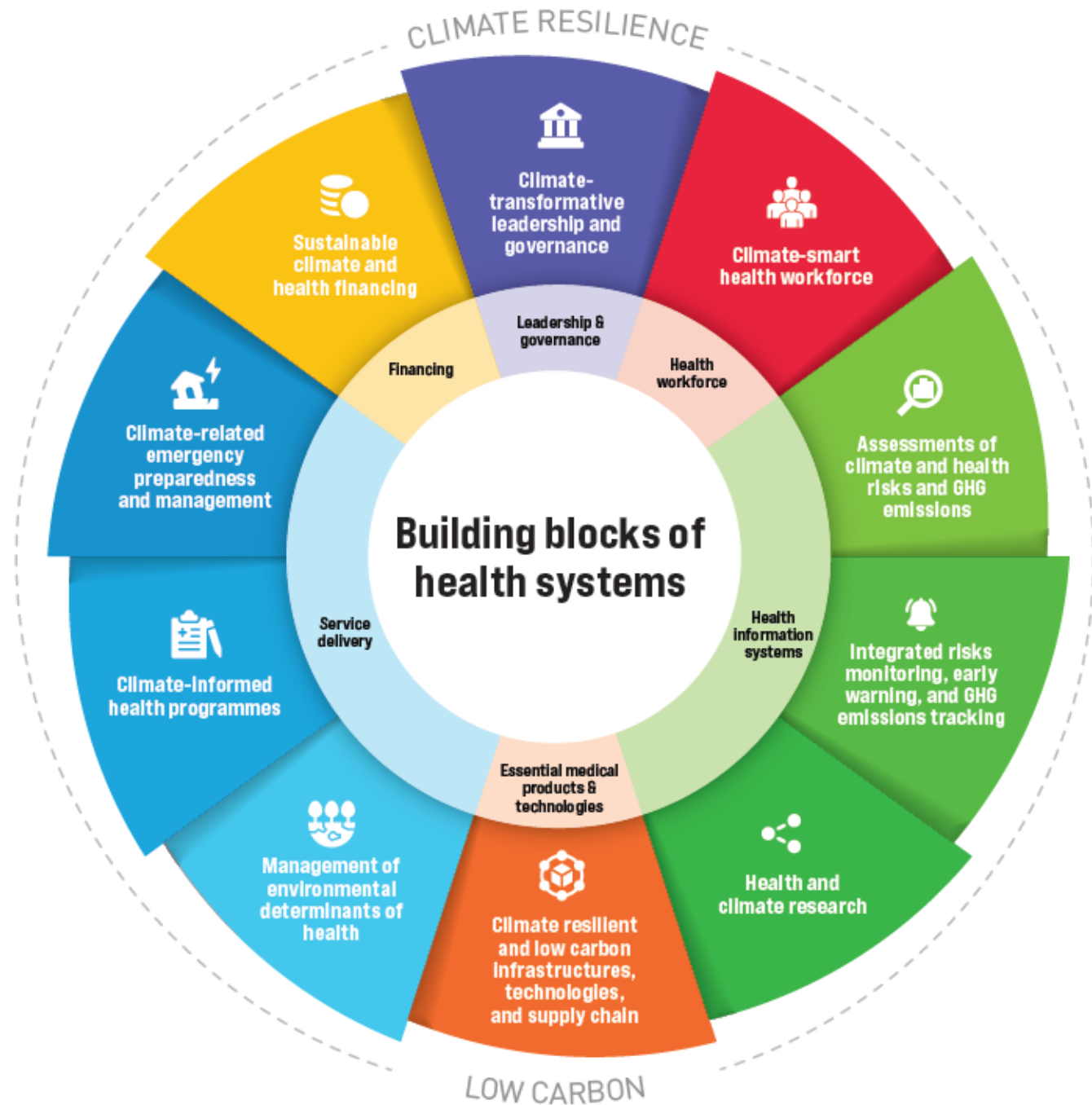


Fig. 5.1. Operational framework for climate resilient and low carbon health systems



Source: Operational Framework Climate resilient Low Carbon Health Systems, WHO 2023

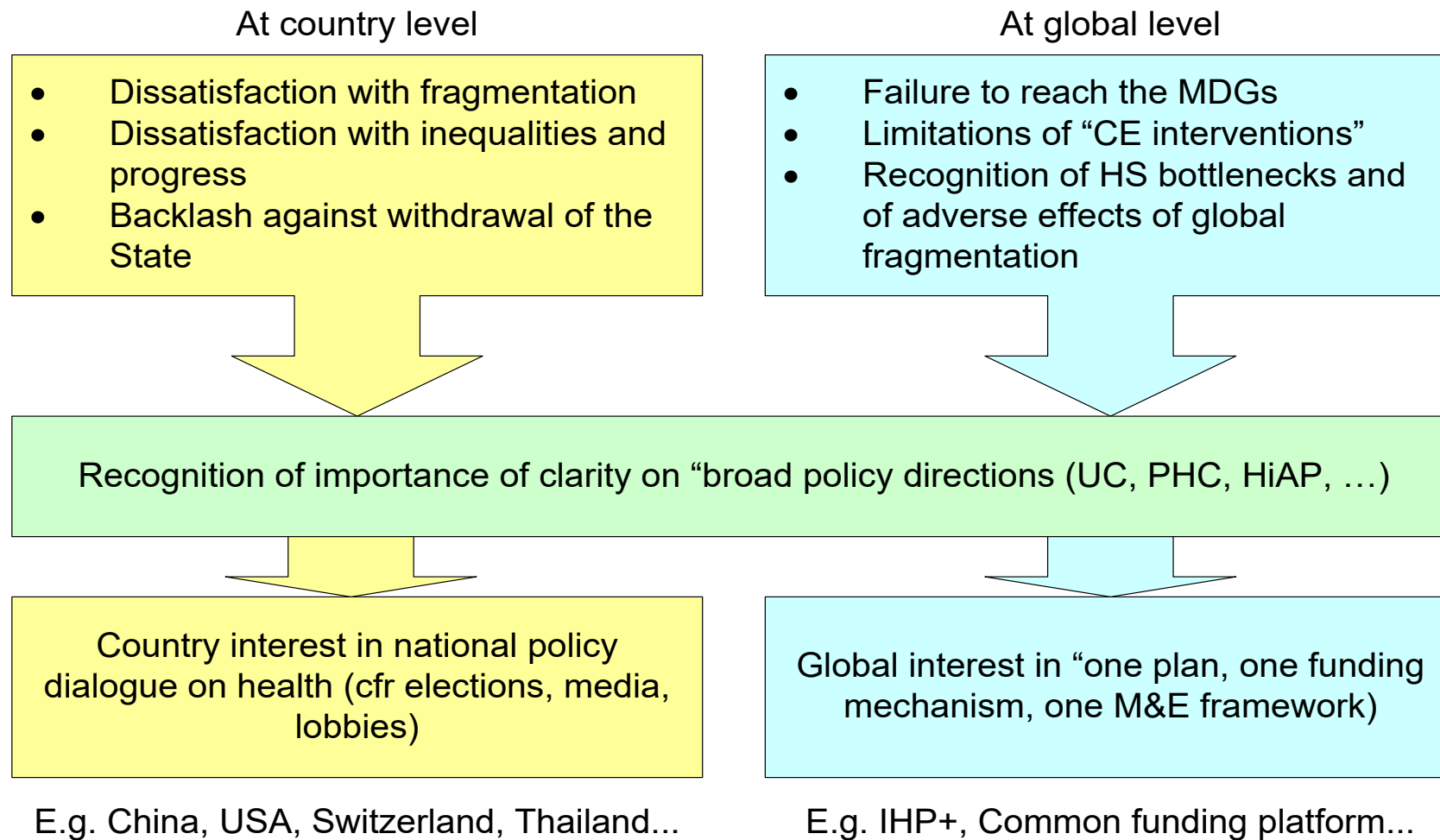
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Que peut-on faire en pratique ?

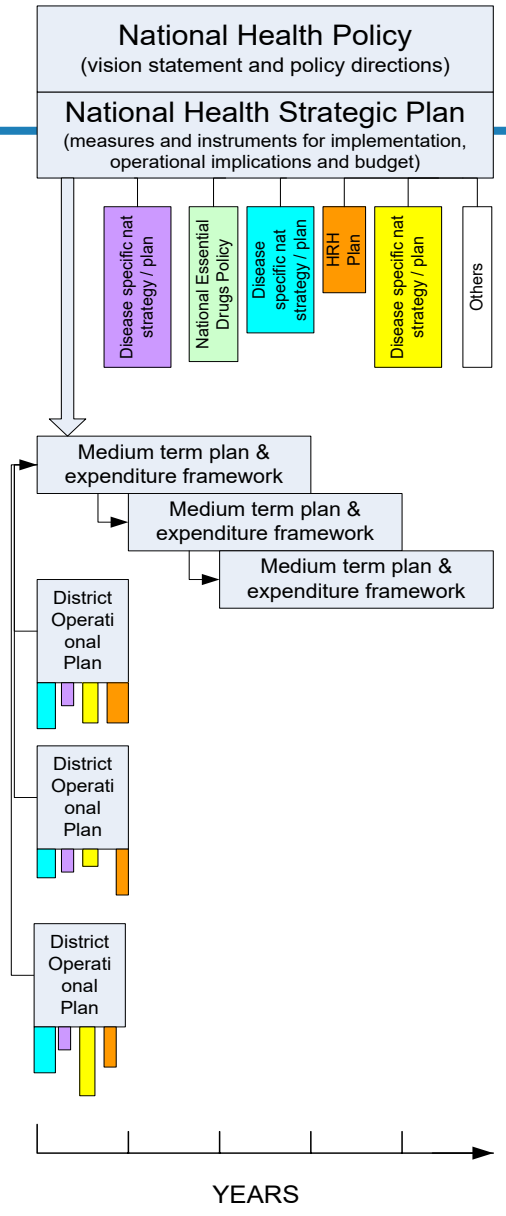
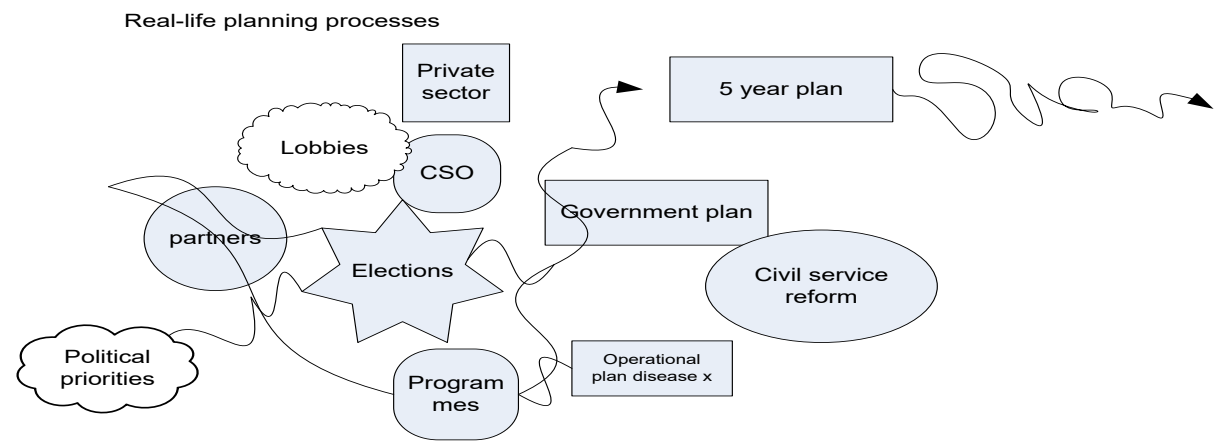
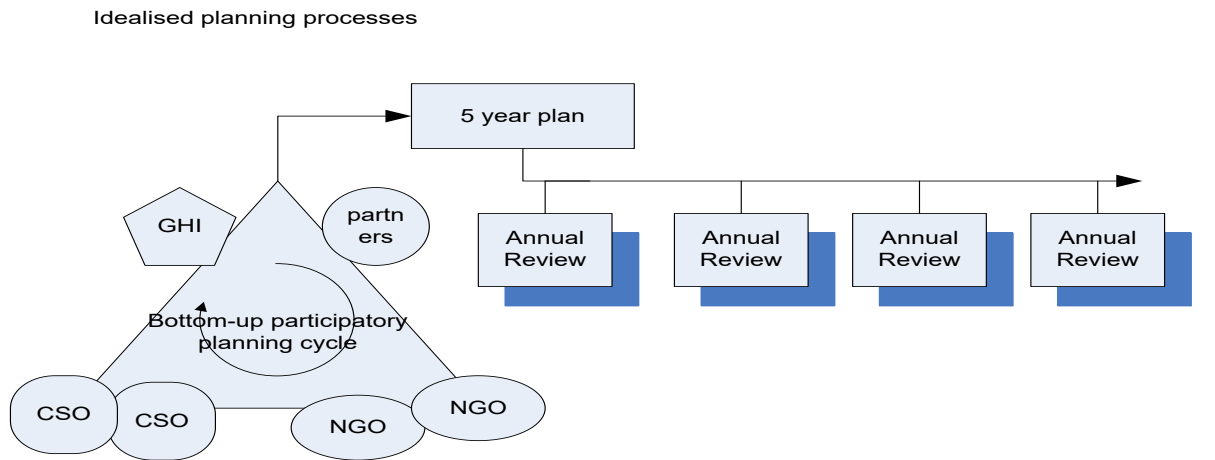
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# LES PLANS NATIONAUX DE SANTE

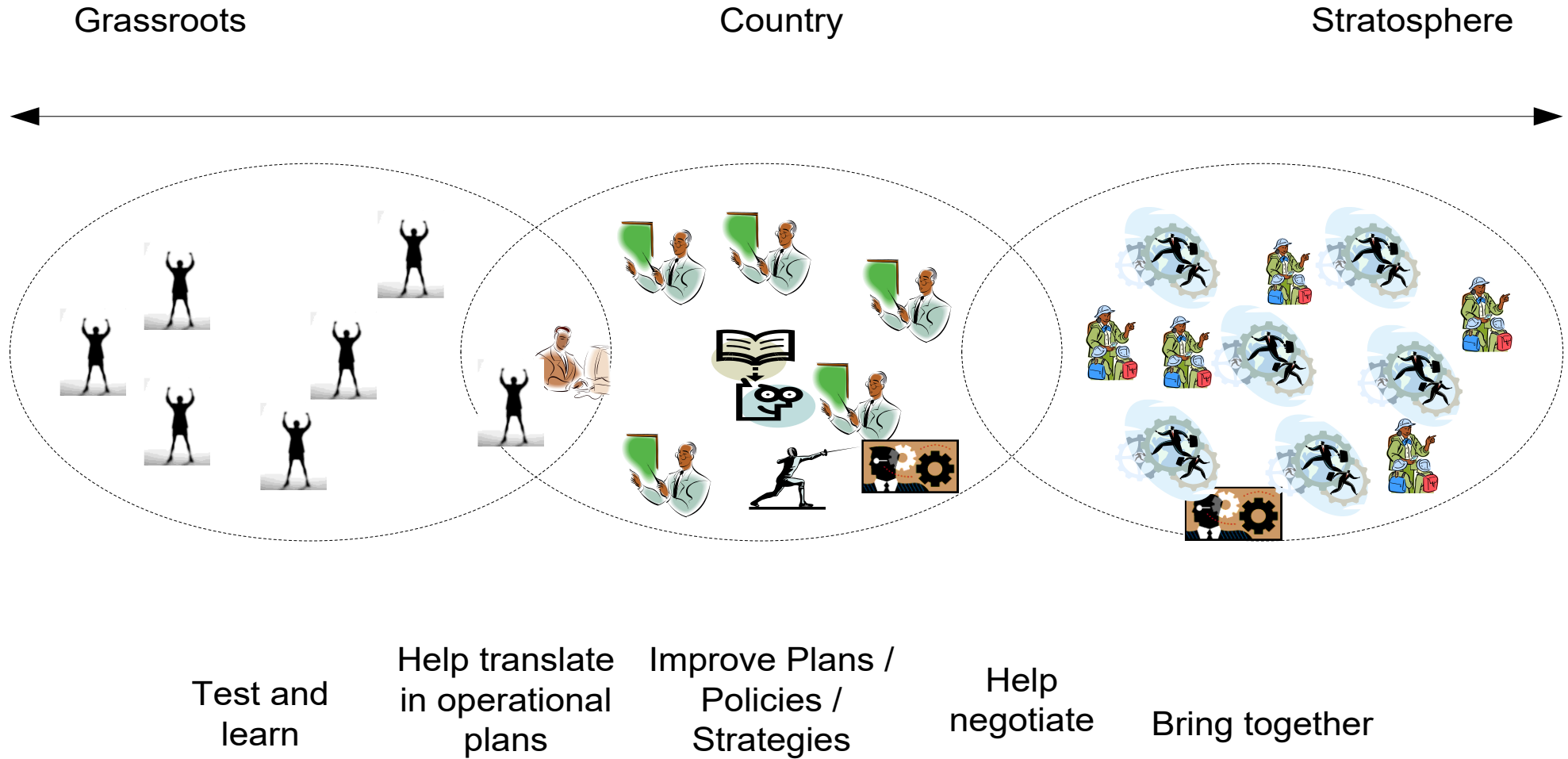
# La réponse mondiale aux défis sanitaires est complexe : ...en termes de PLANIFICATION et de Gouvernance



# C'est compliqué: des processus, des parapluies et beaucoup de confusion terminologique



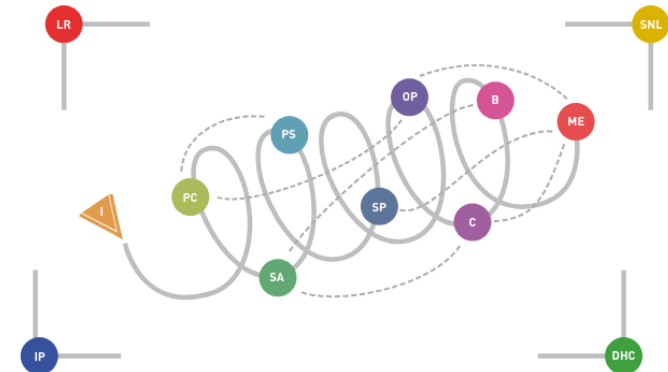
# Où faut-il travailler?



# Ce que l'OMS devrait faire

- Au niveau pays:
  - Des plans meilleurs: globaux, équilibrés, mis-en-oeuvre, synchronisés, appropriés
  - Des processus meilleurs: inclusifs, orientés vers des résultats
  - Des services intégrés: SSP, CSU, Santé Pour Tous
- A l'interface :
  - Renforcer la capacité de négociation
- Au niveau global:
  - l'effectivité de l'aide et ses conséquences
  - L'importance de voir la santé dans un contexte societal global (crises, acteurs,...)

## Stratégies nationales en santé au XXIe siècle - Guide pratique



Edité par  
Gerard Schmetts – Dheepa Rajan – Sowmya Kadandale

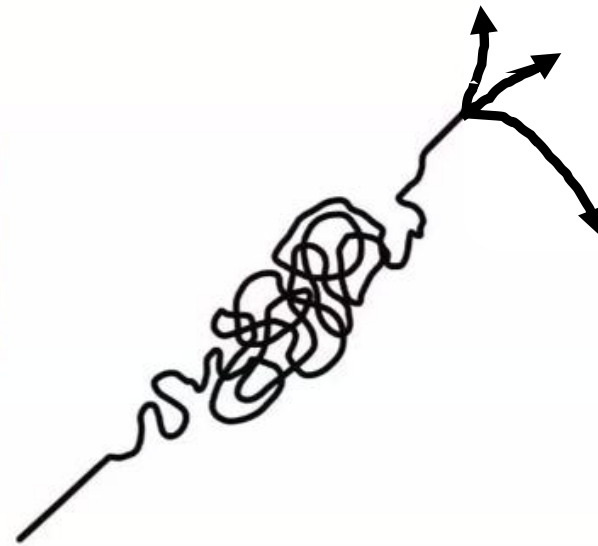
<https://www.who.int/fr/publications-detail/9789241549745>

**SUCCESS**



**WHAT PEOPLE THINK  
IT LOOKS LIKE**

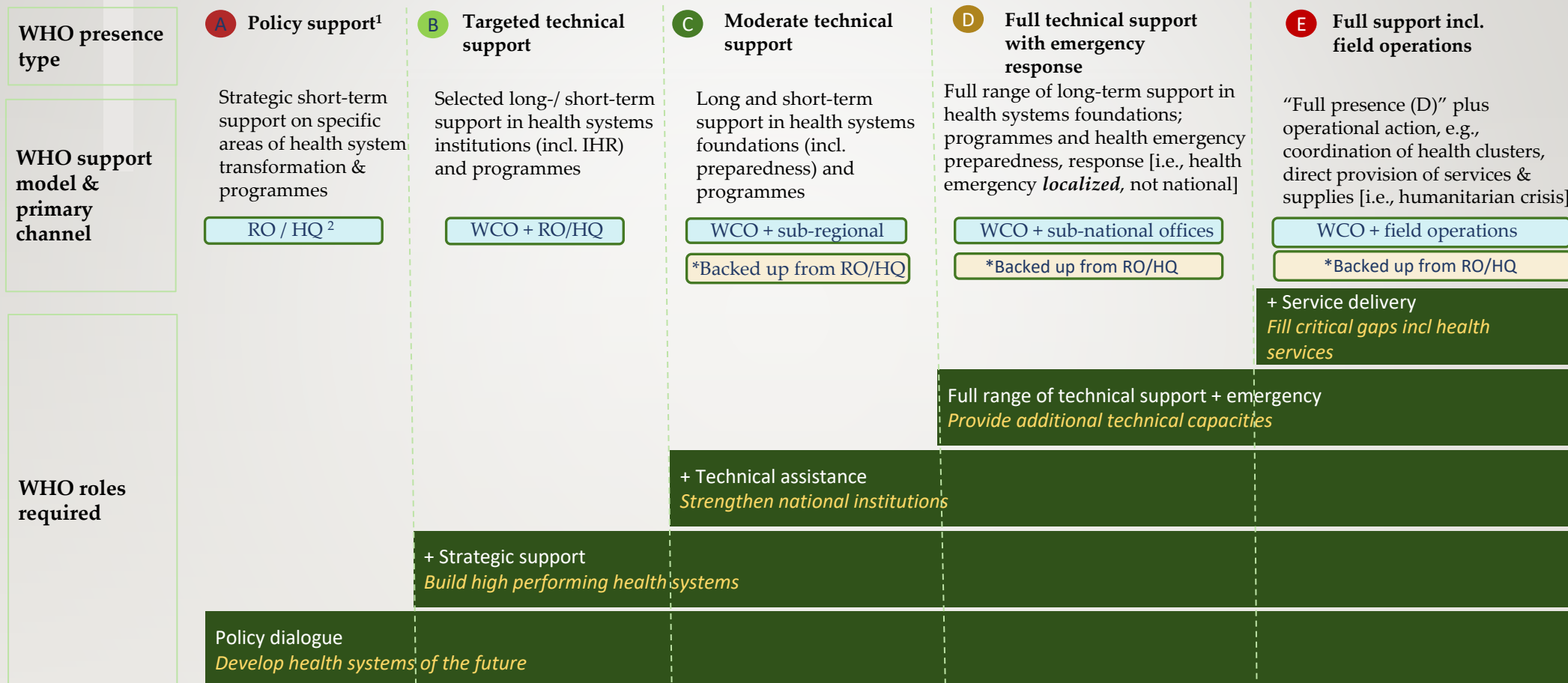
**SUCCESS**



**WHAT IT REALLY  
LOOKS LIKE**

# Core predictable WHO country presence

## Differentiated approach



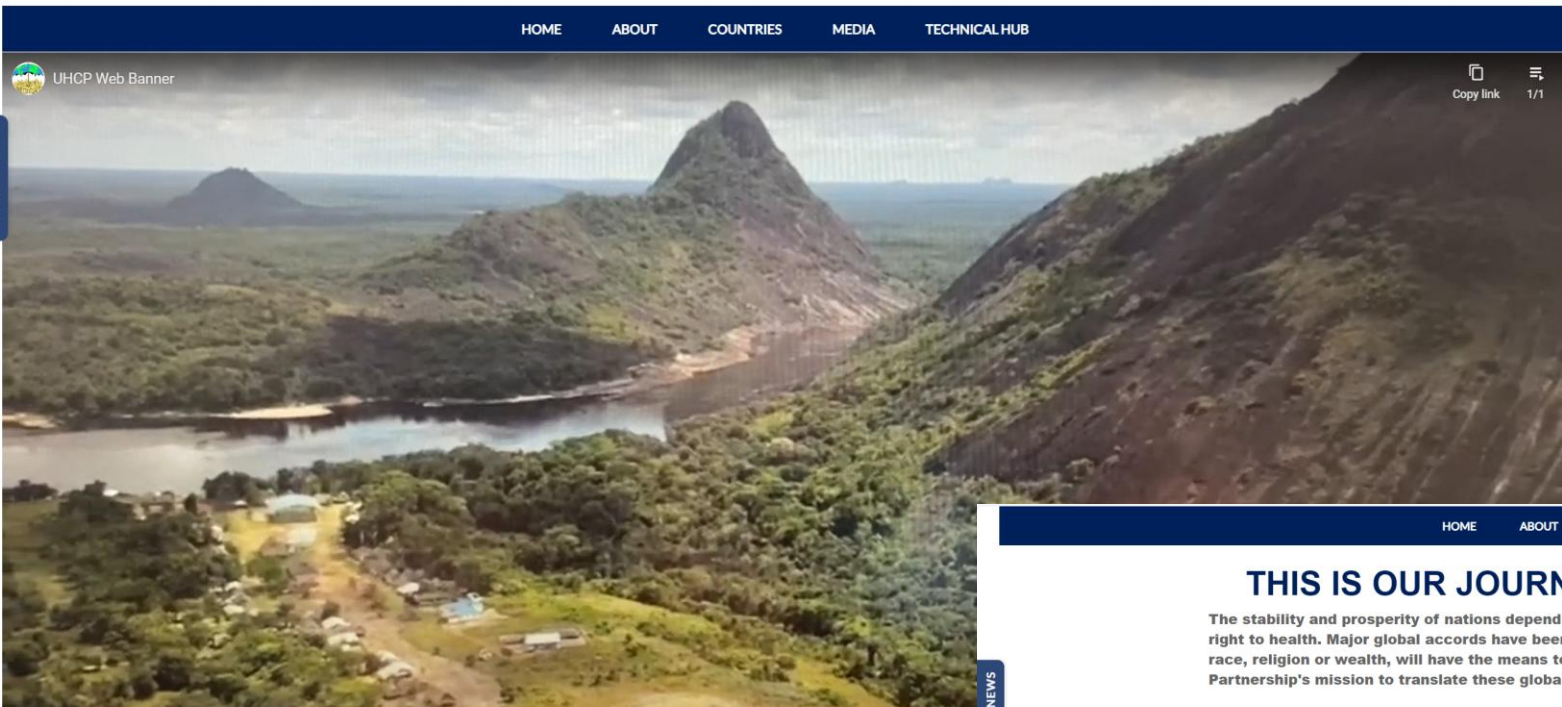
<sup>1</sup> support may be provided through a liaison or desk office

<sup>2</sup> for highly-specialized support or as requested by Regional Offices

# Un exemple d'appui pays relatif aux politiques de santé et à la planification stratégique



Universal Health Coverage Partnership



## THIS IS OUR JOURNEY TOWARDS HEALTH FOR ALL

The stability and prosperity of nations depend greatly on the investments we make in fulfilling the fundamental human right to health. Major global accords have been made, promising a future where everyone, regardless of age, gender, race, religion or wealth, will have the means to attain the highest possible standard of health. It is the UHC Partnership's mission to translate these global commitments into action at country level.

[Main Home Page | Universal Health Coverage Partnership \(who.int\)](https://www.who.int/universal-health-coverage)



Ctrl+Click to follow link

- Timor-Leste:** Saving lives through critical care in remote mountainous regions. 22 March, 2024. #Health workforce #Primary health care #Universal Health Coverage
- Mauritius:** Integrated health care for older people in the Republic of Mauritius. 7 March, 2024.
- India:** Bringing primary health care to remote populations in Chhattisgarh. 31 January, 2024. #Primary health care
- Bahama:** The Bahama population effective vaccine. 13 April. #COVID-19 #Vaccines

[VIEW ALL STORIES](#)

# Et ça marche...

## Basic indicators

No	Indicators	2010	2015	2022
1	% of population who have been covered by PHC services.	82%	92%	97%
2	% of PHC facilities which are provided with equipment	76%	85%	92%
3	Average number of visits to PHC	4,8	5,5	7,6
4	% of public expenditure for PHC from total public budget for health	34,6%	35,1%	40,7%
5	% PHC facilities which are working according to the family medicine principles	56%	74%	88%
6	% of PHC facilities which are using evidence based medicine clinical protocols	67%	79%	93%
7	Number of doctors and nurses who have been covered by family medicine training	Doctor: 271 (4,4%) Nurse: 327 (3,0%)	Doctor: 4154 (7,7%) Nurse: 6652 (62,3%)	Doctor: 4597 (82,3%) Nurse: 9669 (73,4%)

## PROGRESS-2



Construction and repair of 80% of PHC  
89% were equipped



The first elements of digitalization have been introduced

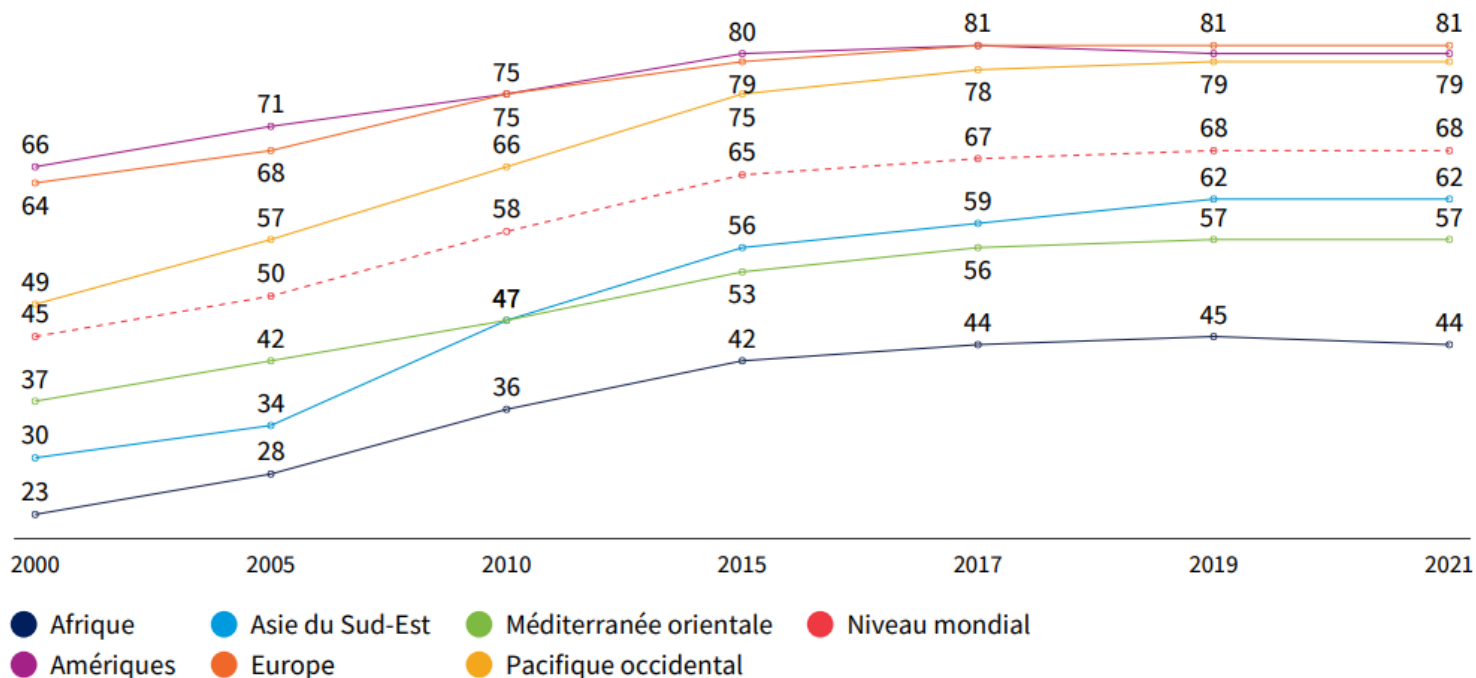


The share of health care institutions operating in family  
medicine has reached 86% (in 2010 – 56%)



The average number of visits to health care institutions is  
7.6 visits per person in 2022 (in 2010 – 4.8 visits)

Figure 15 : Évolution de l'indice de couverture universelle des services de santé, par Région de l'OMS



Source : WHP 2023

## Impact sur la santé des populations

Baisse de  
**38 %**  
du taux de mortalité  
maternelle, 2000-2020

**54 % à 74 %**  
augmentation  
de la proportion  
d'accouchements  
assistés par du  
personnel qualifié,  
2012-2022

Baisse de  
**53 %**  
de la mortalité chez  
les moins de cinq ans  
depuis 2000

Source: Une décennie de transformation 2015-2024. Amélioration de la santé des populations en Afrique - OMS AFRO, 2025



**Pause**

---

# **QUAND ON PARLE D'ÉLABORATION DE POLITIQUE ET DE PLANIFICATION, DE QUOI PARLE-T-ON?**

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# *Quelques exemples*

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# TUNISIE : LE DIALOGUE SOCIÉTAL

# An example... Tunisia [1/4]

- Contexte post révolution Printemps Arabe en 2010-11
- Support to the MoH starting 2011 to Strengthen the MoH capacity (steering and technical committees)
- In 2012, 4 thematic working groups (UHC, Soc. Determinants Health, Governance, & Human resources + health information)
- What are the Perception and expectations of the population? -> choices on policy options... launch of the "societal dialogue"

# An example... Tunisia [2/4]

- As a result, 20 focus groups with population and specific targets, thematic workshops, use of key informants, expert panels
- Weekly broadcast programme "santé et société" on national TV
- High level of motivation/commitment of various individuals and groups involved
  - Local consultants are supporting the thematic group (2 of them are continuing on a voluntary basis)
  - Meeting every month of the thematic groups
  - Restricted committee informs the Minister every month of the activities
  - None of the members of the various committees is remunerated

# An example... Tunisia <sup>[3/4]</sup>

- End of 2013 validation of the thematic reports internally and with "grands regards" from outside
- In 2014, large public consultation more than 4000 people in the 12 Governates of the country
- In September 2014, first ever "Conférence nationale de la Santé", the Prime Minister receives from the population a "Livre Blanc" summarizing their expectations for the Health system reforms

# An example... Tunisia [4/4]

- In 2017, redynamisation du processus pour développer une nouvelle politique nationale de santé et un nouveau plan sanitaire 2019-2024.



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# **SYRIE : RECONSTRUIRE LA GOUVERNANCE DU SECTEUR DE LA SANTÉ**



## Perspectives on Rebuilding Health System Governance in Opposition-Controlled Syria: A Qualitative Study

Yazan Douedari, Natasha Howard<sup>1</sup>

**Table 1.** Health System Governance Elements and Key Findings

Governance Elements	Description
Strategic vision	<ul style="list-style-type: none"><li>Leaders have a broad long-term perspective on health and human development, a sense of strategic directions for such development, and understanding of historical, cultural and social complexities.</li></ul>
Participation and consensus orientation	<ul style="list-style-type: none"><li>All men and women have a voice in decision-making, either directly or through legitimate intermediaries representing their interests.</li></ul>
Rule of law	<ul style="list-style-type: none"><li>Legal frameworks pertaining to health should be fair and enforced impartially, particularly laws on human rights related to health.</li></ul>
Transparency	<ul style="list-style-type: none"><li>Free flow of information for all health matters, with processes, institutions and information directly accessible and sufficiently informative for those concerned.</li></ul>
Responsiveness	<ul style="list-style-type: none"><li>Institutions and processes should try to serve all stakeholders, to ensure that policies and programs are responsive to service-user needs.</li></ul>
Equity and Inclusiveness	<ul style="list-style-type: none"><li>All men and women should have opportunities to improve or maintain their health and wellbeing.</li></ul>
Effectiveness and efficiency	<ul style="list-style-type: none"><li>Processes and institutions should produce results that meet population needs and influence health outcomes while making the best use of resources.</li></ul>
Accountability	<ul style="list-style-type: none"><li>Decision-makers in government, the private sector, and civil society organizations involved in health are accountable to the public and institutional stakeholders.</li></ul>
Information and intelligence	<ul style="list-style-type: none"><li>Intelligence and information are essential to provide evidence for informed decisions that support, or do not conflict with, the strategic vision for health.</li></ul>
Ethics	<ul style="list-style-type: none"><li>Public health ethics include nonmaleficence, beneficence, dignity, justice, and respect for autonomy, which are important to safeguard service-user interests and rights.</li></ul>

---

# FRANCE: LA COMPLEXITÉ...



## *Un première illustration: la France...*

Le système de santé représente un poids considérable dans l'économie française : 12,4 % du PIB, avec un montant de la Dépense Courante de Santé qui pèse 284,6 milliards d'Euros en 2020, en augmentation de 4,6% par rapport à 2019. C'est un secteur dont l'organisation est d'une très grande complexité, que l'on peut illustrer à l'aide de quelques chiffres : 3000 hôpitaux et cliniques répartis entre 3 statuts, 8000 EHPAD, 290 000 médecins libéraux, 600 000 infirmières libérales, 439 entités qui exercent une activité de complémentaire santé en France, ...



«Il est temps (...) qu'un institut français de santé et des instituts régionaux de santé publique soient créés pour une santé publique de territoire simplifiée, associant les collectivités et les populations autour d'une agence régionale et territoriale de santé renforcée afin de répondre à ces questions de fond, sauf à faire du mécano institutionnel qui brouillera d'autant plus le paysage déjà complexe. (...).»

«Nous plaidons donc pour un Plan national de la santé publique et interpellons le président de la République sur l'urgence à combler notre retard en matière d'inégalités sociales et territoriales de santé.»

Source:

**Lettre ouverte au président de la République : plaidoyer pour la santé publique**

Frédéric Denis, rédacteur en chef de la revue Santé publique

Emmanuel Rusch, président de la Société française de santé publique

*Santé publique volume 34 / N°2 - mars-avril 2022*

## Public health in Germany: structures, dynamics, and ways forward

Hajo Zeeb, Julika Loss, Dagmar Starke, Thomas Altgeld, Susanne Moebus, Karin Geffert, Ansgar Gerhardus

Despite Germany's robust economy, comprehensive social welfare system, and the country ranking third among Organisation for Economic Co-operation and Development countries in terms of per-capita health spending, its health indicators still lag behind those of other European nations. Germany also has one of the highest prevalences of major modifiable risk factors for non-communicable diseases within the EU. This Health Policy provides an overview of the development, structures, and actors in public health in Germany, highlighting possible explanations for the country's underperforming health indicators and suggesting a way forward. This Health Policy is structured along the essential public health operations. We identify the absence of a strong central institution for public health, inadequate funding for disease prevention and health promotion, and little interoperability in data collection as major challenges. The country's decentralised governance structure allows flexibility, especially at the community level, but leads to scattered responsibilities and little coordination between sectors. We also note the absence of a public health strategy. The current system's focus on curative care and individualised medicine has led to a neglect of disease prevention and health promotion. Furthermore, the country's strong economic interests and powerful lobbies have hindered the implementation of effective public health policies. To address these challenges, we recommend developing a public health identity, creating a comprehensive public health strategy, fostering a culture of health promotion and disease prevention that encompasses all areas and does not shy away from tackling the commercial determinants of health, and strengthening the connection between medicine, public health practice, and research.



Lancet Public Health 2025;  
10: e333-42

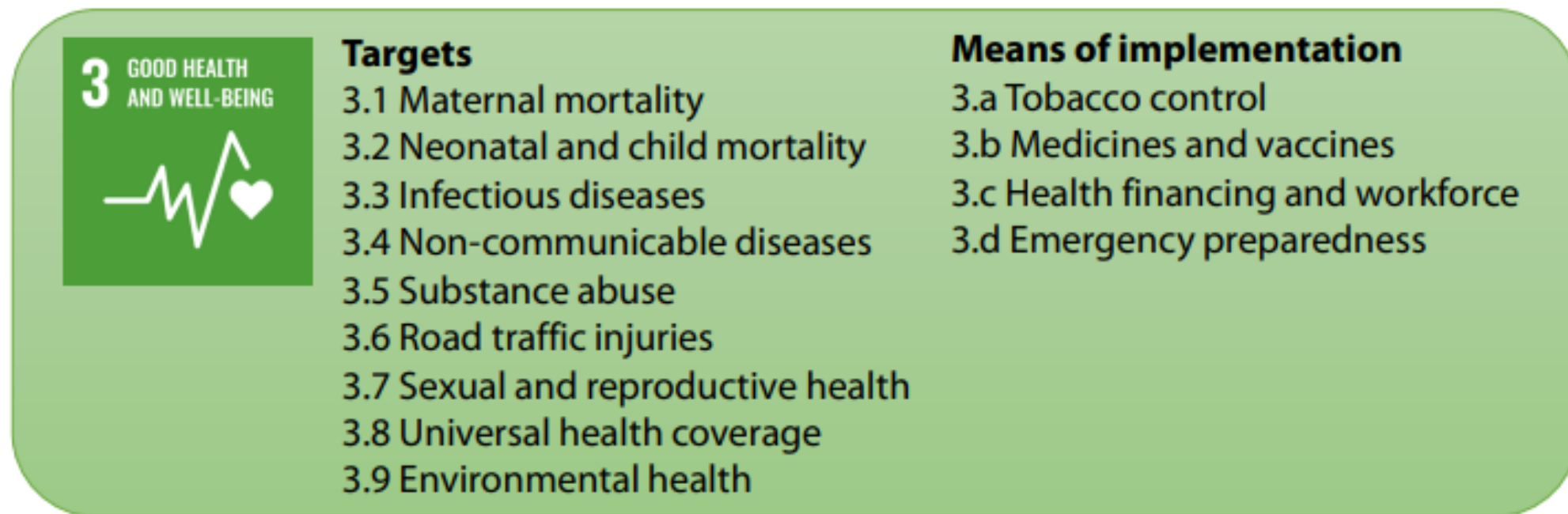
Published Online  
March 3, 2025  
[https://doi.org/10.1016/S2468-2667\(25\)00033-7](https://doi.org/10.1016/S2468-2667(25)00033-7)

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Association for Health and



# Revenons un instant sur la couverture sanitaire universelle...

Figure 1 – SDG3 health and well-being targets



Source: ECA, based on WHO.



## The perpetuation of a disease focused approach

Source--Global Health 2050: the path to halving the probability of premature death by mid-century... [50 by50]

Jamison D *et al*, The Lancet 2024

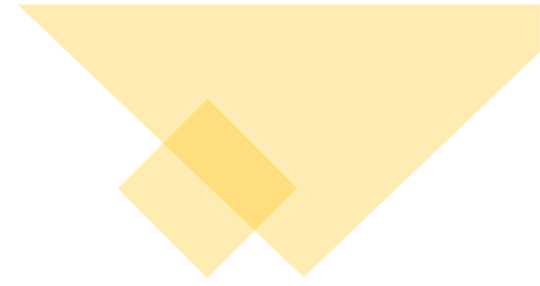

### Panel 3: The 15 priority conditions

We propose that all countries focus on reducing mortality and morbidity from 15 priority conditions, which include eight infectious and maternal health conditions and seven NCD and injury-related conditions. The eight infectious and maternal health conditions were defined using the WHO Global Health Estimates categories of country-level causes of death: **neonatal conditions, lower respiratory tract infections, diarrhoeal diseases, HIV/AIDS, tuberculosis, malaria, childhood cluster diseases, and maternal conditions.**<sup>27</sup>

The neonatal conditions comprise the Global Health Estimate categories of preterm birth complications, birth asphyxia and birth trauma, neonatal sepsis and infections, and other neonatal conditions (eg, haemorrhagic and haematological disorders, transitory endocrine and metabolic disorders, and digestive disorders). The category of childhood cluster diseases comprises four vaccine-preventable illnesses: whooping cough, diphtheria, measles, and tetanus.

The seven NCD and injury-related conditions are **atherosclerotic cardiovascular diseases** (ischaemic heart disease and ischaemic stroke), **haemorrhagic stroke, NCDs strongly linked to infections, NCDs strongly linked to tobacco use, diabetes** (including chronic kidney disease due to diabetes), **road injury, and suicide**. The NCDs strongly linked to infections are stomach cancer, liver cancer secondary to infection with hepatitis B virus or hepatitis C virus, cervical cancer, rheumatic heart disease, and cirrhosis due to infection with hepatitis B virus or hepatitis C virus. The NCDs strongly linked to tobacco use are chronic obstructive pulmonary disease and cancers of the mouth, oropharynx (lip and oral cavity, nasopharynx, and other pharynx), trachea, bronchus, lung, and larynx. Tobacco-related deaths from atherosclerotic cardiovascular diseases and haemorrhagic stroke are included in those categories.

NCDs=non-communicable diseases.



# Social participation & community engagement

**Objective:** institutionalize community engagement mechanisms into health governance processes - which can then be used in service of an emergency response



## Handbook on Social Participation for UHC

- Conference copy launch: Dec. 2020
- Official launch: May 2021



## DG-CSO dialogue series (Oct 2020, Jun 2021) Webinar series on social participation for UHC

- 4 webinars (2020)
- 4-month civil society consultation
- to provide feedback on the contents of the Handbook (2020)



**THIRD CIVIL SOCIETY DIALOGUE WITH WHO DG**

**SOCIAL PARTICIPATION AND ACCOUNTABILITY WITHIN AND BEYOND THE COVID-19 PANDEMIC**

We have the pleasure to invite you to an interactive dialogue with WHO leadership on the promotion of social participation and accountability as a core element of good governance. This invitation is open to all civil society members. Read the input paper: <https://bit.ly/3GZ6VYX>

Submit questions on Slide: <https://bit.ly/3GZ6VYX>

**SAVE THE DATE**

**TUES, 13 OCTOBER 2020**  
14:00-15:30 CEST  
15:00-16:30 EAT  
12:00-13:30 UTC

**Panel 1: WHO to promote social accountability beyond providing "technical" guidance to countries**

With WHO leadership including:

- Dr. Diana Numbuye-Nsubuga (WHO Director General)
- Dr. Khalid Toure (WHO Deputy Director General)
- Prof. Khama Chakraborty (WHO Deputy Director General)
- Dr. Teodoro Villarroel (WHO Deputy Director General)

**Panel 2: WHO to consistently deal with institutional civil society interaction as a matter of social accountability**

Moderated by:

- Angela Nguu (WHO Deputy Director General)
- Thomas Schwarz (WHO Deputy Director General)
- Dr. Jake Slett (WHO Deputy Director General)
- Dr. Justin Koonin (WHO Deputy Director General)



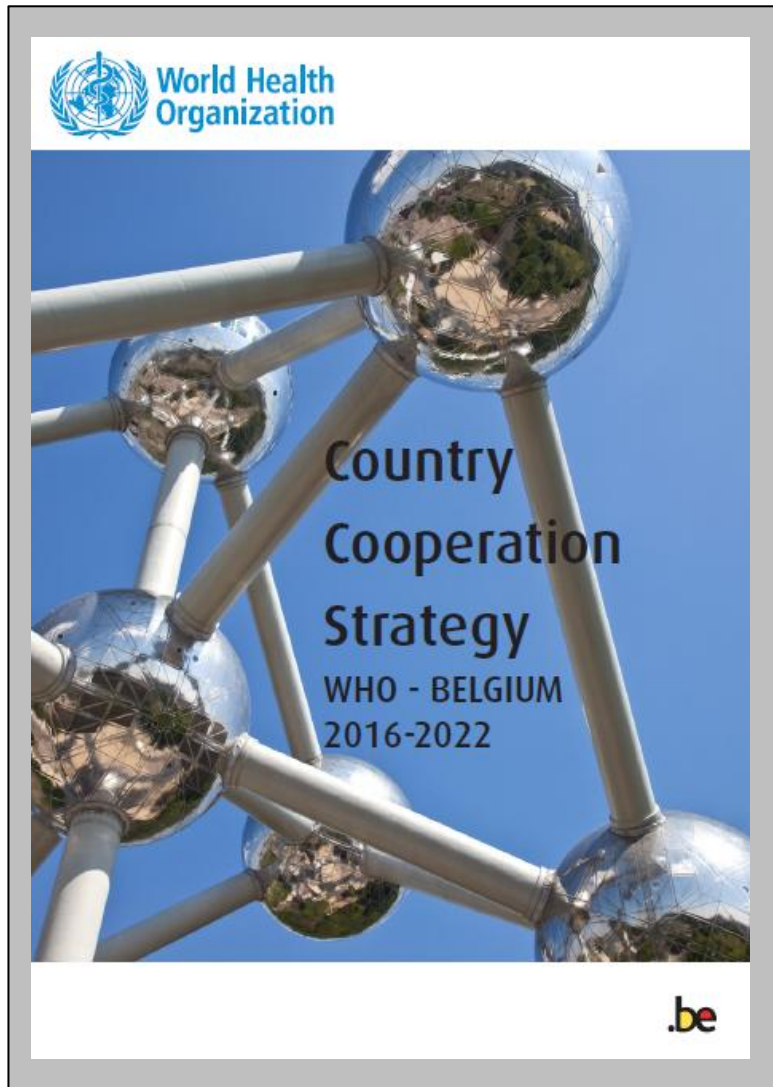
## Publications:

- **BMJ Global Health 2020** "Governance of the Covid-19 response: a call for more inclusive and transparent decision-making" (<https://gh.bmj.com/content/5/5/e002655>)
- **BMJ Global Health 2020** "Symptoms of a broken system: the gender gaps in COVID-19 decision-making" (<https://gh.bmj.com/content/5/10/e003549>)
- **Eurohealth 2021** "The health democracy deficit and COVID-19" (<https://apps.who.int/iris/handle/10665/338949>)

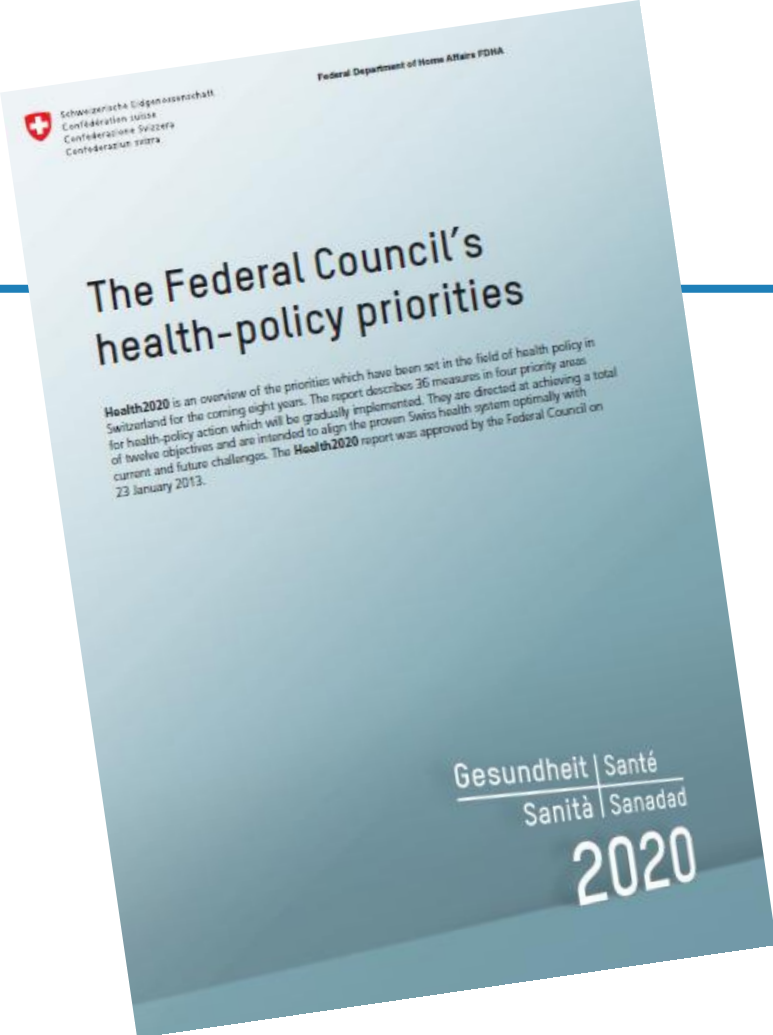
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# **LES PAYS D'EUROPE DE L'OUEST ET LEURS PRIORITÉS**

# L'OMS a une stratégie de coopération (CCS) avec la Belgique : 5 priorités stratégiques



- Systèmes de santé centrés sur la personne
- Maladies non transmissibles
- Préparation aux urgences, surveillance et réponse
- Santé et environnement
- Maladies transmissibles



<b>3 Priority areas for policy action, objectives and measures</b>	<b>6</b>
Priority area 1: Ensure quality of life	7
Objective 1.1: Promote modern forms of healthcare delivery	
Objective 1.2: Complement health protection	
Objective 1.3: Intensify health promotion and disease prevention	
Priority area 2: Reinforce equality of opportunity and individual responsibility	9
Objective 2.1: Reinforce fair funding and access	
Objective 2.2: Keep health affordable by increasing efficiency	
Objective 2.3: Empower insurees and patients	
Priority area 3: Safeguard and increase the quality of healthcare provision	11
Objective 3.1: Promote quality in services and healthcare delivery	
Objective 3.2: Make greater use of e-health	
Objective 3.3: More and well-qualified healthcare workers	
Priority area 4: Create transparency, better control and coordination	13
Objective 4.1: Simplify the system and create transparency	
Objective 4.2: Improve management of health policy	
Objective 4.3: Reinforce international integration	
Interdependencies between the various priority areas, objectives and measures	15



**Merci!**