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Role of Primary Care in Health Systems Strengthening Achievements, Challenges, and Suggestions

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Abstract

Primary health care (PHC) is critical in working towards universal health coverage and meeting health-related Sustainable Development Goal (SDG) targets, especially in areas where health resources are limited. Although progress on SDG health targets is inconsistent and slow in many areas of the world, there is substantial research that attention to PHC can improve SDG attainment outcomes and contribute to strengthening health systems. A PHC approach to health systems strengthening can achieve this by maximising the availability and distribution of healthcare focused on meeting individual and community health needs along the continuum of life. This includes health promotion, disease prevention, diagnosis, treatment and treatment coordination, rehabilitation, mental health, and end-of-life care, which is conveniently located within easy access to individual's everyday environment and without causing significant disruption to day-to-day life. As such, PHC places particular emphasis on integrating primary health practitioners in the wider public health systems, thereby making them the first point of call in seeking non-urgent health information. This, in practice, also allows PHC practitioners to coordinate care and focus on the long-term care of the whole patient and their families. This paper will outline the role of PHC in practically achieving this, as well as the strategic and operational players needed to support community focused comprehensive PHC, with mention to the more recent challenge of responding to a global pandemic while continuing to invest in resilient health systems built on a supported PHC frontline.

Keywords

Primary Care, Health Systems Strengthening, Global Health, Astana Declaration, Covid-19, Multi-Disciplinary Care

1. Global Health Perspectives on Primary Care

PHC, as first defined in the Alma Ata declaration in 1978, is summarised as first contact essential health care that meets the needs of communities, is easy to access and is acceptable and affordable (Declaration of Alma Ata, 1983; Rifkin, 2018). The declaration combined three elements considered core to delivering sustainable and equitable health services: multisectoral public policy; empowered communities; and primary public health care (Rifkin, 2018; World Health, 1988). In 2019, this international commitment to strengthening PHC with a view to achieving universal health coverage and quality health for all was reaffirmed through the Declaration of Astana, making pledges in the following areas: making bold political health choices; sustainability in PHC; empowering communities; and stakeholder support to policies, strategies, and plans (Kluge et al., 2019). When a health system can sustainably achieve these elements, it will in theory successfully achieve the goals envisaged in the Alma Ata declaration and the subsequent Astana declaration.

Although the Astana declaration follows through and reiterates the core values established 40 years prior in the Alma Ata declaration, a comparison between the two reflects how PHC attitudes changed over this time. Whilst, the Alma Ata declaration primarily focused on establishing PHC systems, mainly in countries with underdeveloped health systems, the Astana declaration reemphasised the importance of sustainable health systems. It also adopts an ambitious scope in challenging PHC to address current health challenges so that the relevance of PHC reforms is not missed (Jungo et al., 2020). In reflecting changes in society's needs and attitudes towards PHC, the goals of the Astana declaration aim to reframe the international commitment to innovative, accessible, inclusive, and evidence based PHC systems. There was a particular focus on countries with already established PHC structures, reemphasising the importance of universal health coverage and of robust PHC structures relevant to the health needs of the populations it serves, with recognition of the increasing importance of chronic disease (Jungo et al., 2020). In line with changing doctor-patient relationship—shifting from a paternalistic to a more partnership approach to healthcare delivery—the new declaration included statements on empowerment and health literacy. This reflected the shift in the public understanding of the patient's role in primary care so that patients could have increased control over health decisions (Jungo et al., 2020; Kluge et al., 2019; World Health, 1988).

A shared criticism of both declarations has been that while they have attempted to reflect the public health values of their times, experiences in implementation over the 40 years and evidence of the declarations' successes and challenges have been difficult to quantify for several reasons. Firstly, the specific actions needed to achieve health for all are absent in both declarations. As such, a mismatch arises between the ideal and what is practically feasible in the developing and developed populations (Walraven, 2019). Secondly, in attempting to view PHC as a blueprint rather than a process, the contextual intricacies and

health challenges of nation states are downplayed, such that the effect of culture, politics, economic and political stability, and social concerns might be ignored. The efficacy of PHC therefore needs to be addressed by frameworks that account for this complexity. Research assessing progress has only recently started to respond to this need (Dodd et al., 2019). Finally, the process by which goals from the declarations are evaluated and translated from research institutions to medical systems, healthcare professionals and to patients continues to be a challenge even within high income countries (Yallop et al., 2006). For this reason, knowledge and data sharing through new medical IT data systems have been suggested as a potential solution to streamline multi-disciplinary and multi-national collaboration to further develop the primary healthcare research fronts (Jungo et al., 2020; Yallop et al., 2006).

2. Successes in Primary Health Care

Primary care forms an essential level of a health system aiming for universal health coverage, akin to being the base of a pyramid of health care levels coordinating care between the levels and acting as an initial source of contact for patients outside of the emergency setting (**Figure 1**). Other levels include secondary, tertiary and emergency care (examples include serious injury, illness, or acute trauma). They are differentiated by the duration of the care provided, how they are accessed, and the number of specialised resources required for the purposes of navigating the diagnostic or therapeutic dilemma (Starfield, 1994). Each level is necessary for universal health coverage as they incorporate the full spectrum of essential health services required across the lifespan in a community, from health prevention, treatment, chronic disease control, rehabilitation, and palliative care. PHC forms an important component of universal health coverage as PHC practices exist within communities, thereby increasing access to basic healthcare for individuals including in non-metropolitan settings with a generally

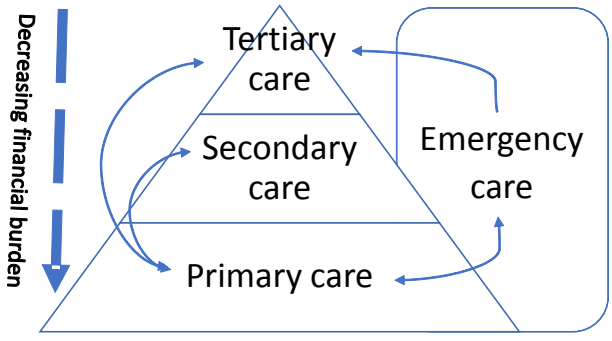

Figure 1. Schematic of the role of primary care in coordinating care between different health levels. In an ideal system, primary care physicians are readily accessible within the community and incur a minimal financial burden on the system and patients by requiring minimal specialised clinical resources. It is important to note that for universal health coverage to be successful, all the other levels of care need to be well integrated with primary care such that both primary care physicians and patients receive clear plans and consistent advice.

lower financial burden. The success of this is that it allows individuals to access healthcare services capable of addressing common causes of disease, thereby contributing to health equity (Harrold et al., 1999).

Increasing rates of non-communicable disease and longer life expectancy has meant that more patients require long term care (Dodd et al., 2019). PHC clinicians are ideally suited to deliver such care. In both developing and developed countries, PHC has been linked to increased access, improved health outcomes, lower hospitalisation rates and less Emergency Department presentations, particularly in places affected by poor economic conditions (Shi, 2012). It is hypothesised that this is best achieved when PHC forms the first level of care (Starfield, 1994). Earlier studies comparing specialist care with generalist care argued that specialists were more efficient and accurate in presentations relating to their specialty, however by no means for all diseases (Fendrick et al., 1996; Harrold et al., 1999). This argument is particularly important when considering that patients commonly present with general symptoms attributable to a wide net of conditions or symptoms that may be difficult to pin to a definitive diagnosis.

The paradox becomes that although PHC physicians in the literature appear to provide poorer quality care for specific diseases than in a specialist-focused health system, primary care is associated with superior health outcomes at the level of the whole person, and greater equity, lower costs, and higher quality care at the population level (Stange & Ferrer, 2009). This important focus on the whole person is missed when making direct comparisons of PHC focused versus specialist focused health systems. This paper argues that disease-specific research that does not acknowledge the suitability or importance in co-management of common disease is reductionist in its assessment of health care performance. For example, the management of diabetes complications requires coordination between several medical and allied health professionals (Lall & Prabhakaran, 2014). To expect that patients can recognise and navigate multidisciplinary, sustained care on their own, or for specialists to be able to coordinate care outside their area of expertise, is ambitious, particularly in patients from vulnerable backgrounds. In a PHC focused health system, a primary care general practitioner would provide education, progress follow-up and help coordinate care between the health levels. Secondary level care specialties might include scheduled reviews by ophthalmology, endocrinology, or renal medicine. In complicated diabetes, patients may require tertiary management of bone infections in hospital under vascular surgery, or present to the Emergency Department after a fall or with a worsening poorly-healing leg wound. Central to providing optimum care of chronic disease, of which diabetes is one of many, is the integration of these health levels with patients' regular primary care physician.

The importance of PHC clinicians as gatekeepers to specialist surgical services has also been recognised since the 1970s. In one study, the appropriateness and clinical outcome of tonsillectomy and adenoidectomy were better when patients were referred by a PHC clinician than when they had been self-referred, suggesting that self-referred patients are likely to suffer from higher rates of unne-

cessary intervention and greater financial burden (Roos, 1979). Although in some cancer studies a small proportion of self-referred patients experience higher rates of curative surgery by arriving to a diagnosis faster, rates of self-referral were found to vary between patient race and socioeconomic status (Pollack et al., 2015). White patients were more likely to self-refer compared to Black patients, and self-referral was strongly associated with higher levels of education and income (Pollack et al., 2015). For this reason, a health system that allows people to bypass primary care practitioners is likely to reinforce health disparities in care and limit progress towards universal health coverage.

3. Discussion of Global Challenges and Next Steps

Strengthening health systems by investing in better primary care results in a more equitable distribution of health resources within a population, however, this is not without its challenges (Shi, 2012; Shi, Macinko, Starfield, Politzer, Wulu, & Xu, 2005; Starfield, Shi, Grover, & Macinko, 2005; Starfield, Shi, & Macinko, 2005). PHC needs to be adequately resourced to fulfill its purpose, with public funding for clinicians to be widely distributed amongst urban and rural populations, and adequately supported by a well-integrated referral system to higher level care providers (Shi, Macinko, Starfield, Politzer, Wulu, & Xu, 2005). Many of the issues raised by primary care clinicians in the developed world include long hours, dissatisfaction in referral processes, high responsibility, poor salaries, and pressure to see a high volume of patients daily for sustainable income (Freeman et al., 2021; Phillips, 2005). High rates of burnout means that continuity of care can be interrupted and access to a high performing generalist workforce dwindles in the long run as fewer clinicians are inclined to work in primary care (Karuna et al., 2022). The services of PHC clinicians in developed countries, such as the US and Australia, have been undervalued both within academic circles and by public health funding, which is often diverted to cover overspending on investigations and procedures in secondary and tertiary public care facilities (Freeman et al., 2021; Phillips, 2005). Underinvestment and recruitment problems can make it difficult for clinicians in the field to sustain the care they provide and work towards health system strengthening. Updating electronic health records and bidirectional team-based communication are necessary in creating a sustainable and robust health system built on primary care, but often requires great time expense in a frequently overworked PHC clinician (Murphy et al., 2012; O'Malley et al., 2015).

Another challenge for health systems strengthening and universal healthcare coverage in many countries is access to affordable medications and investigations. For example, essential asthma and chronic obstructive pulmonary disease (COPD) medication and diagnostic tests are difficult to access and remain largely unaffordable in Uganda; salbutamol inhalers costed 2.2 days' wages of the least paid government employee, longer acting corticosteroid inhalers were worth 17.1 days' wages and spirometry required almost a months' worth of wag-

es (Kibirige et al., 2017). Even in well-established PHC systems with good access to primary care physicians, government subsidies for essential medicines and robust referral pathways, an integral component of optimal healthcare at a population level is highly dependent on the equitable access to affordable medication and diagnostic investigations, especially for patients from vulnerable backgrounds. In Australia, additional pharmaceutical subsidies implemented in 2010 for Indigenous Australians with chronic disease increased medication use nationally and was associated with marked declines in chronic disease hospitalisation in Indigenous patients—hospitalisation decreased from 103.4/1000 in 2009 to 60.0/1000 in 2011 (Trivedi & Kelaher 2020; Trivedi et al., 2017). It can be argued, therefore, that the role of primary care in health systems strengthening would be incomplete if it does not include considerations of access to affordable medicines to the individuals and communities it aims to serve.

In recent times, an additional challenge to health systems globally has been the Covid-19 pandemic, which has reinforced the importance of the role of PHC in systems strengthening by being the frontline force of health systems (WHO, 2021). In addition to strained hospitals, staff shortages, limited equipment, medications and medical resources, individuals with chronic conditions faced a double disadvantage in that they were both vulnerable to severe Covid-19 infection and were likely to experience indirect health effects from disruptions in regular healthcare (Kim et al., 2020). Diagnoses of cancer, chemotherapy appointments, and visits to Emergency Departments for critical presentations such as myocardial infarction and stroke all decreased during the pandemic but was followed by a secondary surge in delayed presentations (Kim et al., 2020). Different countries tried to strengthen the primary care frontline to reduce the burden on hospitals and protect patients from interruptions to regular healthcare, and in doing so, make better use of the skills and services available in primary care. These included:

- Establishing networks and team practices to share the clinical load in the community and compensate for PHC staff shortages (OECD, 2020a).
- Allowing pharmacists to extend prescriptions for chronic disease medications in response to interruptions in regular healthcare (Merks et al., 2021).
- Using digital tools such as e-Health and telemedicine to help maintain continuity of care, support and treat patients remotely and reduce virus spread (OECD, 2020b).
- Provide stimulus payments in recognition of the increased risks and higher workload PHC providers face in pandemic situations (OECD, 2020b).

Emerging research will in time evaluate how these policy levers in PHC strengthen the health system's response to health emergencies and support the long-term care of its people and communities.

4. Conclusion

Primary healthcare plays a crucial role in health systems strengthening in work-

ing towards universal health coverage and in meeting health-focused SDG targets. These systems can take decades to implement and require continued investment in PHC policy levers and research. The successes in lasting PHC reforms are most evident in systems that integrate primary care into the wider health system, encouraging bidirectional communication and collaboration to support care for patients in the community. Currently, care for disease in hospital is rewarded and supported to a greater degree, an imbalance which has caused challenges in the health care system, particularly during the Covid-19 pandemic. Ensuring that PHC continues to be at the forefront of policy building and investment will help support strengthening of health systems during the pandemic and its aftermath. Further studies looking into PHC systems that were supported during the Covid-19 pandemic and critically analysing their successes would be beneficial in laying groundwork for other PHC systems to take on board. Evaluating the resilience of current PHC systems in responding to Covid-19, and other pandemics would be particularly beneficial in future planning. Research into the system-wide and local elements that support a robust and well-resourced primary care frontline is an integral part of the ongoing efforts to develop primary care systems.

The factors that support robust and resilient health systems are many. PHC strengthening not only reduces disease burden at an individual level, but also reduces the financial burden at an organisational level by reducing hospitalisation and the economic impact of a higher disease burden. Furthermore, they provide accessible healthcare opportunities across the lifespan of an individual and play a key role in interacting within the different levels of the healthcare pyramid for appropriate healthcare delivery. Based on these findings, it is the opinion of the authors of this paper that systems need to be supported financially and through government level policies to be sustainable.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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