WALKING THE TALK: REIMAGINING FIT-FOR-PURPOSE PRIMARY HEALTH CARE

WHY, WHAT, HOW

Outline

- Primary Health Care: Time to Deliver
- Reimagining Primary Health Care
- Reimagining Primary Health Care - What & How
  - Breakdown of four high-level structural shifts using the three reforms
- Looking ahead

Primary Health Care: Time to Deliver

- 40 years after the Alma-Ata declaration on primary health care (PHC), the Astana declaration reemphasizes the importance of **renewing political commitment to PHC, and achieving universal health coverage (UHC)**
- A primary health care approach focused on **organizing and strengthening health systems** is required to achieve UHC

Overview

- Health systems founded on well-functioning PHC provide health security, stability, and prosperity
- The COVID-19 pandemic has inflicted devastating health and economic costs, but also created a once-in-a-generation chance for transformational health-system changes
- PHC has unique capabilities to help systems meet challenges such as urbanization, persistent high burden of preventable diseases, but features of traditional PHC systems must evolve to take full advantage of existing strengths and build new ones

Reimagining Primary Health Care

WHAT IT IS		WHAT IT IS NOT
PHC meets people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course	NOT	PHC does not mean basic, or rudimentary health care nor first-contact care
It systematically address[es] the broader determinants of health (including social, economic, environmental, as well as people's characteristics and behaviors) through evidence-informed public policies and actions across all sectors	NOT	Primary health care does not equal gate keeping
It empower[s] individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and care-givers to others	NOT	Integrating primary care and public health to improve population health is not a supplementary enhancement of PHC. It is already part and parcel of PHC
A health- and social-service delivery platform uniquely designed to meet communities' health and health care needs across a comprehensive spectrum of services – including health services from promotive to palliative – in a continuous, integrated, and people-centered manner	NOT	Primary health care does not mean first-contact care, nor the first level of care in the health system. First-contact care could be emergency medical services

Reimagining primary health care will require four high-level structural shifts using three priority reforms

Four fundamental shifts in PHC design, financing, and service delivery

PHC is great, **BUT IT CAN DO BETTER**

1. From dysfunctional gatekeeping to **QUALITY, COMPREHENSIVE CARE FOR ALL:** An ambitious shift that strengthens the range and quality of services that obtainable at PHC facilities

2. From fragmentation to **PERSON-CENTERED INTEGRATION:** a shift toward cohesive local PHC teams centered around patients' needs

3. From inequities **TO FAIRNESS AND ACCOUNTABILITY:** Make policy and implementation choices that support the equitable, efficient delivery of essential service packages

4. From fragility to **RESILIENCE:** Ensure that financial and human-resource surge capacity is built into health sector planning and resource allocation at local levels

Reimagining primary health care will require four high-level structural shifts using three priority reforms

High-performing PHC delivers required care at the most appropriate level of the health system

From dysfunctional gatekeeping to QUALITY, COMPREHENSIVE CARE FOR ALL

Treat all patients with respect and build care around patients' need and preference

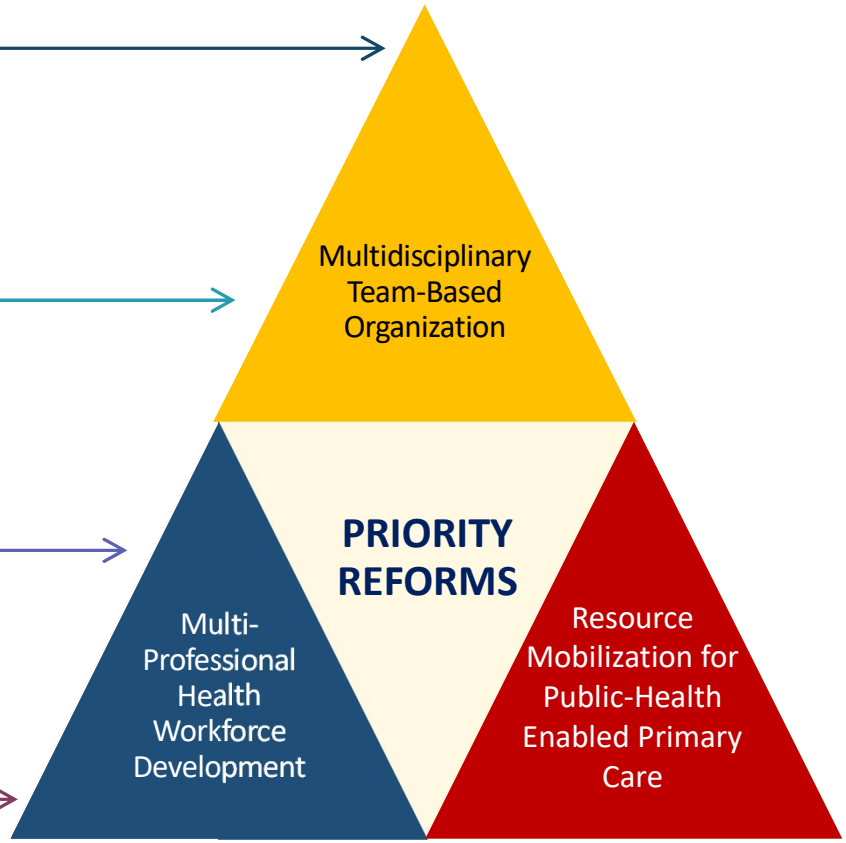
From Fragmentation to PERSON-CENTERED INTEGRATION

Deploy policies that support equitable, efficient delivery of a PHC-driven essential service package

From Inequities to FAIRNESS AND ACCOUNTABILITY

Build financial and human-resource surge capacity into health sector planning and resource allocation at the local level

From Fragility to RESILIENCE



Structural Shift #1:

From dysfunctional gate-keeping to QUALITY, COMPREHENSIVE CARE FOR ALL

Shift 1: From dysfunctional gatekeeping to quality, comprehensive care for all

Reform 1: “fit for purpose” **multidisciplinary team-based organization**

Active community-oriented outreach model through a multidisciplinary core team of health service providers to meet a full range of local health needs

Patients are assigned (“empaneled”) to dedicated PHC professionals who facilitate access to comprehensive PHC services and coordinate care with the other levels of the health system

Clear delineation of responsibilities will be necessary in the construction of the primary care team (CHW, nurses, doctors, pharmacists)

Shift 1: From dysfunctional gatekeeping to quality, comprehensive care for all

Reform 2: “fit for purpose” **multi-professional health workforce**

High-quality PHC delivery will require changes in how health workers are trained, deployed, managed, evaluated, and paid

Medical education reforms should embed education within community clinical settings and orient medical graduates to generalist/primary care specialization

“Task-shifting” selected care tasks to non-physician health workers under physician supervision optimizes the use of higher-skilled cadres

Shift 1: From dysfunctional gatekeeping to quality, comprehensive care for all

Reform 3: “fit for purpose” **financing for public-health enabled primary care**

Increase in government revenue facilitates equitable access to health services and improves financial protection for the population

A prioritized health benefits package for primary care, customized to the local burden of disease, community values, and citizen preferences is a justification for resource allocation

Donors can also contribute to more resilient health systems by investing in surveillance and public health functions

Structural Shift #2:
From fragmentation to PERSON-CENTERED INTEGRATION

Shift 2: From fragmentation to person-centered integration

Reform 1: "fit for purpose" ***multidisciplinary team-based organization***

Multidisciplinary teams build long-term trust with empaneled communities, creating a strong foundation for care continuity

Proactive PHC teams can act as traffic dispatchers, triaging patients across different levels of care in an agile manner and in accordance with their health needs

Where specialist services are not co-located or provided as integrated single-day services, technological solutions can play a useful role in strengthening referral processes

Shift 2: From fragmentation to person-centered integration

Reform 2: "fit for purpose" ***multi-professional health workforce***

Reorienting medical education and on-the-job training to build workforce competencies necessary for delivering integrated patient-centered care

Two set of skills are cross-cutting: how to use and interpret data, and soft skills such as leadership, communication, and relationship building.

Primary care teams need well-aligned quality measurement that promotes accountable performance by rewarding team members for creative thinking, problem solving and managing complexity

Shift 2: From fragmentation to person-centered integration

Reform 3: "fit for purpose" ***financing for public-health enabled primary care***

Aligning provider payment mechanisms with the team-based integrated person-centered vision will be critical.

Team-based care and coordination with other care providers can be explicitly incentivized through direct payment linked to such activities, e.g., pay-for-coordination

Several payment models can *indirectly* incentivize or facilitate care coordination and integration – both vertically and horizontally

Structural Shift #3:
From inequalities to FAIRNESS AND ACCOUNTABILITY

Shift 3: From inequalities to fairness and accountability

Reform 1: “fit for purpose” ***multidisciplinary team-based organization***

Extending care into the communities to address disparities in health outcomes by supporting basic health education, nutritional coaching, etc.

Multidisciplinary care teams assigned to a defined catchment population are held accountable for patient experience and health outcomes of the empaneled population

Public reporting, timely data collection and benchmarking can increase PHC professional's awareness and understanding of their performance

Shift 3: From inequalities to fairness and accountability

Reform 2: "fit for purpose" ***multi-professional health workforce***

Proactive polices for workforce development, deployment, and regulation can address the maldistribution of health workers across countries

Regulatory reforms can enable telehealth's potential and potentially break geographical barriers to care

Use of incentives to promote health worker performance, accountability, and to encourage rural service

Shift 3: From inequalities to fairness and accountability

Reform 3: "fit for purpose" ***financing for public-health enabled primary care***

Access barriers need to be removed to ensure equity. PHC should be free at the point of care.

PHC teams need to be accountable for the experiences and health outcomes of the entire empaneled population. Accountability can be enhanced through the process of empanelment and intergovernmental fiscal transfer.

Empowering PHC teams and communities helps to improve participation in decision-making regarding how resources are allocated to respond to population health needs

Structural Shift #4:
From fragility to RESILIENCE

Shift 4: From inequalities to fairness and accountability

Reform 1: "fit for purpose" ***multidisciplinary team-based organization***

Integrated and team-based PHC platforms can and should include explicit data collection, public-health, and surveillance functions, integrated with national systems

Established relationships and trust between the PHC team and community can enable effective communication and behavior change during an emergency

Multidisciplinary team-based PHC platforms offer benefits for preparedness, response, and resilience in emergencies

Shift 4: From inequalities to fairness and accountability

Reform 2: "fit for purpose" ***multi-professional health workforce***

Health workforce education and training should encompass mastering technical and non-technical skills related to managing emergencies in the community

Make provision for comprehensive and agile psychosocial support to health workers—both during and in the aftermath of a crisis to mitigate resultant stress, exhaustion, and trauma

Use of incentives to promote accountable health worker performance

Shift 4: From inequalities to fairness and accountability

Reform 3: "fit for purpose" ***financing for public-health enabled primary care***

Have systems in place that guarantees the ability to surge the required funding to the front lines before and during a crisis

Rapid deployment of additional funding to the frontlines may require adjustments to typical payment mechanisms

An explicit health benefits package, defined during a period of relative calm, may need to be rapidly amended so the health system can respond to a crisis

Looking Ahead:

What can countries do?

What can partners do?

Three mechanisms that World bank will use to support countries:

lending, learning and leadership

Practical prerequisites for translating reimagined PHC into actionable policies

Implementing four structural shifts: recommendations for countries

SERVICE DELIVERY

- Equip care teams to build community connections and trust through outreach and communication activities
- Broaden access to digital platforms and leverage data analysis capabilities to improve outcomes

HEALTH WORKFORCE

- Develop and implement a multi-pronged, multidisciplinary set of medical education reforms to plug gaps and optimize training for community-focused, team-based care
- Ensure that compensation for health workers (e.g., salaries or reimbursement rates) in rural or underserved areas is at least equivalent to compensation in more saturated urban regions

FINANCING

- Build commitment and buy-in across government to secure funds for reimagined PHC
- Craft a fit-for-purpose investment plan that is rooted in a comprehensive package of services and is free at the point of service

Implementing four structural shifts: recommendation for donors and the international health community

- Support systematic documentation, evaluation, and learning on countries' experience around different team-based care models
- Work collaboratively to raise international recognition of community-based medical education and qualifications
- Fund country-led multidisciplinary medical education reform
- Foster innovations, technology adoptions, and new initiatives through financial support and partnership

The role of the World Bank in supporting countries to deliver the promise of reimagined PHC

- LENDING
  - Work with the Global Finance Facility (GFF) and other partners to **facilitate countries' easy access to funds for PHC-oriented system reforms**
- LEARNING
  - **Strengthen and equip global knowledge hubs for PHC,** including the Primary Health Care Performance Initiative
- LEADERSHIP
  - **Establish a dedicated platform for policy dialogue, advice, and technical assistance** to Ministries of Health and Ministries of Finance


THANK YOU