

Concept note for an investment case for primary health care

Revitalizing Primary Health Care (PHC)

Two decades of encouraging progress in global health are today looking very fragile. Even before the worst pandemic in a century, many countries were not on track to achieve the Sustainable Development Goals targets for health, with progress having largely plateaued in areas such as expanding access to vaccinations and immunizations, TB treatment, and family planning. COVID-19 has made the situation dramatically worse by disrupting services, causing a significant rise in poverty, and straining government budgets precisely when resources for health are most needed.

One of the key challenges that the SDGs and the global pledges to achieve Universal Health Coverage by 2030 have posed was to translate broad and general goals into specific actions that would drive progress that could be measured. The focus on a global price tag, adding up to trillions of dollars over the 15 years between 2015 and 2030, also served as a disincentive by making any realistic investment seem insignificant and unlikely to change the status quo.

Investments in PHC is generally seen as a central pillar in the efforts to achieve Universal Health Coverage as well as any equitable progress in health services in low- and middle-income countries. This was reinforced by the 40th anniversary of the Alma Ata Declaration on Health for All in 2018. However, the Primary Health Care discussion has suffered the same weakness as that of Universal Health Coverage: vague and general aspirations with unrealistic price tags attached.

A consortium of health experts and academics, supported by a grant from the Bill and Melinda Gates Foundation, have attempted to address this challenge. The approach is based on three basic assumptions:

1. A significant improvement in PHC is essential both for progress towards Universal Health Coverage as well as for improving pandemic preparedness and minimizing the long-term consequences of a lengthy COVID-19 pandemic;
2. Evidence-based, targeted, and measurable interventions that would drive significant progress in Primary Health Care can be found, and that they can be financed in similar ways to how disease-specific interventions have been funded with great success through Global Health Initiatives over the past 20 years; and
3. Development Assistance for Health can play an outsized role by catalyzing change and laying the ground for more efficient and coordinated domestic investments in Primary Health Care.

With this starting point, the consortium conducted a review of the literature and identified a long list of 131 PHC approaches. Second, in order to facilitate prioritization, the 131 approaches were grouped into 22 investment areas. Third, a set of criteria were developed to prioritize these investment areas. These criteria included which investment areas were likely to be transformational, promote equity, and contribute to building resilience, and the extent to which they were suited to donor financing. Fourth, an international expert working group of academics and practitioners from eight countries, including low- and middle-income countries, reviewed and refined these criteria and then used them to prioritize an interconnected package of approaches. Finally, the consortium estimated the donor financing required to catalyze scale up of this package in 74 low- and middle-income countries.

The resulting package presented in this paper is backed by a strong evidence base with the proposed approaches having generally been proven effective in rigorous studies. Moreover, countries are already employing them, as highlighted by initiatives such as the Lancet Commission on Investing in Health, WHO's PRIMASYS series, PHCPI's Promising Practices, the World Bank's Business Unusual, and Exemplars in Global Health, all of which have identified countries that are deploying some of these approaches and seeing rapid progress as a result. External support has played an important

role in scaling some of these efforts up but despite this too many of these approaches are not yet operating at scale—and that is likely to remain the case without a concerted push to accelerate progress.

The consortium does not claim to be in a position to make the case for comprehensive PHC. There are many other worthwhile elements that contribute to better health such as better access to water and sanitation, improved nutrition, family planning and sexual reproductive health etc. But the proposed approach tries to provide a suitable entry point for increased investments in PHC that could lead to much better comprehensive systems over time.

Three groups of interventions that could drive a global transformation of Primary Health Care

The result of this analysis is a package of three investment areas: (i) a new model of people-centered primary care, (ii) next generation community health, and (iii) individuals and communities empowered to engage in health decision-making.

These three areas would be supported by strengthening two cross-cutting elements of national systems: the electronic data systems required to track patients, human resources, and supplies in real time; and the educational, training, and supervisory systems needed to improve the quality of care.

Today, care is often siloed, passive and reactive, with failures in prevention and widespread testing. The basic model of facilities relying on sick patients presenting at them is inefficient and inequitable, and it ignores both technological advances that open up new ways of reaching patients and the successful experiences of a number of countries in moving to models that engage entire communities. A new model of people-centered care would include digital diagnostics and clinical decision-support tools. Widespread use of these tools in primary care facilities could be transformational. These digital tools can address the barriers that prevent more disadvantaged populations from attaining quality care. Multi-disciplinary teams can help patients deal with multiple health challenges over the course of their life, allow for complexity to be addressed effectively, and improve efficiency by facilitating the division of labor. The increase in telehealth and technologically enabled community outpost facilities can reach more people, earlier, with more appropriate care without overburdening secondary facilities. Care teams can be held accountable for the delivery of services that maximize the health of the full population of an area, rather than just the subset that shows up to access care.

Community health worker programs are nothing new, but the body of evidence of what works, combined with powerful, new digital technology tools, can revolutionize community care. Such next generation community health worker programs enable an important conceptual evolution: a switch from models in which community health workers focus solely on one disease, to one in which they instead engage with everyone in their communities to provide services that are tailored to their individual situations.

This comprehensive approach would enable active case-finding, which is important for connecting people with health services early in the course of a disease, when treatment is often more effective, as well as delivering benefits for existing programs.

The two first areas should be combined with individuals and communities empowered to engage in health decision-making. There is growing evidence that the empowerment of communities and individuals to become more active participants in the PHC system can have very large impacts on health outcomes. Primary health care in low- and middle-income countries could be radically transformed by strategic, interlinked donor investments to engage communities and individuals through community empowerment efforts and through self-management and self-testing approaches.

Each of the three areas are not entirely original or new; on the contrary, they are well-tested and have proven effective in country-settings, but they are yet to be brought to scale. However, the rapid evolution in the power of digital tools and big data to increase efficiency and reach indicate that the interventions can be significantly more transformative and effective than in the past.

What sets these investment areas apart is that they are selected to be suitable for manageable levels of donor investments. They are easily definable and delineable in that one can achieve results with these interventions without being dependent on other elements or a broader set of conditions, (such as infrastructure, legal or regulatory framework, assumptions on workforce strength, etc.) for success. They are chosen to fit with a model of performance-based grant funding. And they are possible to start exclusively through a realistic level of external investments, with the possibility of being brought to further scale through domestic co-funding at a later stage.

An investment of US\$1.9–US\$3.8 billion per year can potentially transform primary health care

The investment attached to these interventions is within a realistic scale compared to current development assistance for health. With an additional donor investment of between US\$1.87 billion in a low-investment scenario and US\$3.85 billion in a high-investment scenario annually over the next three years, donors could support the scale-up of the above evidence-based package of investments in the 59 low- and middle-income countries that are eligible for external financing from the World Bank Group’s International Development Association (IDA). With larger investments (US\$3.85 billion – US\$5.75 billion), the additional 15 countries in the next World Bank lending category—so-called “blend” countries—could be covered.

International support for the three investment areas will have a double effect: in addition to the direct improvement of health services, the additional investments have the potential to remove existing bottlenecks in the health systems, which are increasingly an obstacle to the achievement of goals and the long-term impact of the global Health initiatives (GHI) such as GAVI, Global Financing Facility (GFF) and the Global Fund to Fight AIDS, Tuberculosis and Malaria are considered.

The Global Health Initiatives already provide substantial funding for primary health care and have implemented high funding volumes quickly and effectively. Setting up a new funding mechanism would not be an efficient way to increase funding for primary health care. Instead, increasing the inclusion of primary health care in the global health initiatives' funding plans should be the focus. The increase in investments via the GHI should be accompanied by stronger bilateral engagement.

The consortium recommends initiating a comprehensive process for the creation of dedicated primary health care investment plans. This process should bring together a number of partners, especially low- and middle-income countries, donor countries, the global health initiatives, the World Health Organization and other UN agencies, the World Bank and civil society.

The concept note had been initiated by the Joep Lange Institute, through a series of consultations with international organizations, civil society organizations and governments. Subsequently, a consortium of the Joep Lange Institute, SEEK Development and Duke University supported by a grant from the Bill & Melinda Gates Foundation developed the paper.

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