

Primary health care service delivery redesign for the COVID-19 “new normal”

POLICY BRIEF

Evidence from the Western Pacific Region on stewardship of primary health care for effective pandemic response

Health systems in the Western Pacific Region (WPR), like elsewhere, are constantly adapting to contextual changes, such as demographic, economic and climate shifts, as well as variations in the disease burden, such as avian influenza, SARS, an increasing NCDs epidemic and, most recently, COVID-19. These adaptations may result from government stewardship or, in its absence, responses from public and private providers, health workers and communities.

Primary health care (PHC) is a central pillar of every health system and there is thus considerable interest in evidence for how PHC systems have adapted to COVID-19. This policy brief draws on evidence from a review of global literature and interviews with health system analysts and thought leaders in the WPR. It also reflects guidance on PHC as envisaged in the Declaration of Astana, including the WHO and UNICEF Operational Framework and the World Bank’s Reimagining Primary Health Care report. Collectively these findings and recommendations suggest that government stewardship of PHC is essential to the performance of the broader health system, including during a pandemic, and one necessary for moving PHC systems from fragility to a system governed with resilience both every day, and in response to new challenges.

Across the WPR, PHC systems are situated within varied populations, geographies, economies and histories, with health systems at different stages of the pathway towards UHC. These variations shape each country’s experience of the COVID-19 pandemic and ongoing response to it. However, looking across these diverse experiences, there were commonalities in how governments took steps to integrate the public health response at the PHC level, maintain the provision of routine services, and target specific population groups, with evidence emerging of the following:

1. **As health system stewards, governments are in the driver’s seat of pandemic response.** However, while COVID-19 has been disruptive for PHC service delivery, it has less been a driver of major reform to PHC. Rather, COVID-19 has been a catalyst to:
 - Highlight health system challenges and gaps in PHC (e.g.: shortages of human resources for health); and
 - Accelerate, scale or build on existing reforms already underway (e.g.: financing reforms in Vanuatu and Vietnam).

While no country was fully prepared for the impact of COVID-19, strong, long-term public investment in PHC is likely to mean stronger systems each day and stronger responses to pandemics. Increasing budget allocations to PHC in the context of the social and economic recovery from the pandemic will be a challenge, and a multi-year investment program should be advocated for. In addition, evidence of a leading role for public providers in the COVID-19 response suggests there may be a strong case for greater support to these facilities.

2. **Achieving equity in the public health response is an act of stewardship and necessary for an effective response to COVID-19.** In some contexts, governments mobilised new resources in response to the pandemic to expand eligibility for subsidised or free public health interventions including risk communication, screening, triage, testing, and referral, as well as vaccination, to previously excluded populations. In other contexts, governments at national, sub-national or local levels drew on long-term partnerships with marginalised communities, and/or devolved decision making/autonomy for PHC service delivery, which were key to effective public health responses in marginalised communities.
3. **Flexibility in service organisation is dependent on a multiskilled work force, which aids efforts to maintain essential services and integrate the public health responses at the PHC level.** Technical training was rapidly rolled out in some settings while this was not possible in others where limited skills within the existing workforce were often reported to have compromised both the COVID response and maintenance of services. Where human resource shortages exist, they were difficult to overcome in the short term, and necessitate longer term investment. Task shifting was widespread, as was utilisation of community health workers, with the need for service reorganization canvassed in several contexts.
4. **The speed and effectiveness with which governments can steward the introduction of new technologies is dependent on the strength of the existing national regulatory and financing capacity within the health system.** New technology-based solutions for PHC service delivery, as well as new technologies for testing, treatment and vaccination, have been widely proposed and, in some cases, implemented. Regulating and resourcing (financial and human) the introduction of these technologies to scale these solutions has been challenging.
5. **Stewardship and the everyday governance of the health system is a collaborative endeavour and there is evidence of the added value of localised decision making at the national, sub-national and community level to a contextually relevant and effective response.** Parachuted solutions that were not contextually relevant were commonly deemed ineffective. While governance structures vary between countries, building and empowering health system leaders at all levels of the health system is needed while engaging effectively with non-health sector leaders. In addition, the pandemic also highlighted in other ways the importance of extending governance structures to communities. For example, the acceptability of new technologies to the population also proved dependent on a health and/or digital literacy, which the COVID-19 pandemic revealed had converged in new ways (e.g.: vaccine hesitancy). A longer-term response, strengthening connections between PHC and communities, and supporting trusted community leaders is needed.
6. **Improved collaboration within the health sector, and across sectors, at the national, sub-national and local levels, enabled more coordinated and efficient use of resources to support PHC, and also mobilised additional political, financial and social resources. Sustaining this coordination while adapting to the new normal will require significant leadership from all health sector actors at all levels - global, national, sub-national and local – and the continued engagement and will of non-health sector actors to sustain and grow these new relationships.**