Building and Sustaining a Robust Primary Health Care System: Lessons from Country Experiences

Dr. Soham D. Bhaduri[1]

Abstract

Primary health care has been long acknowledged as the fundamental pillar of any health system, and a key instrument for achieving efficient, equitable, and universal health care. While accepting the significance of primary health care to be sacrosanct, little recognition is often accorded to the systemic prerequisites of a strong primary health care system, even as efforts to expand and/or strengthen primary care continue fervently. An attempt has been made in this paper to identify such prerequisites through a review of notable country examples and their present and past experiences. These pertain not just to the health sector but also straddle multiple important social, economic, and political dimensions.

Keywords: Primary health care, general practice, universal health coverage, family medicine, family health team, gatekeeper, community participation, intersectoral coordination

Introduction

The concept of primary healthcare, although as old as organized healthcare itself, rose to prominence at a global level following the World Health Organisation (WHO) Alma Ata agreement in 1978, wherein 134 participant nations of the world recognized health as a foremost human right and swore by the importance of primary healthcare in achieving "health for all" by the year 2000 AD. The year 2000 came and went, but the importance of primary healthcare has never stood to be disputed. Envisaged as the first level of contact of individuals, the family, and community with the national health system, the idea was to make available immediate and basic healthcare as close as possible to where people live and work, referring to higher levels (hospitals and specialists) only those cases as would mandate more advanced interventions and specialized attention. Apart from providing basic and immediate medical care, primary healthcare was to come with an entire range of interventions meant to preserve health; prevent illnesses both in the individual and the community; promote healthy lifestyle practices through means such as health education; and provide rehabilitative aid to those in need of it.

Countries with a robust primary healthcare system have been perennially known to produce better health outcomes at much lesser expenditures, compared to those without one. They have fewer low birth weight infants, lower infant and maternal mortality, a higher life expectancy, and even fewer years of life lost due to suicide.[1] An effectual primary healthcare system has special relevance to the rural population, where medical attention maybe few and far between. It is in such deprived settings that availability of primary healthcare becomes a critical determinant of access to healthcare, in both physical and economic terms.

A number of prerequisites exist for a well-functioning primary health care system. Many of these are attributable to the larger health system that primary care forms a subsystem of. Some of the factors influencing primary care include the presence of a suitably trained and oriented primary health care workforce; suitable regulatory and incentive structures for both patients and providers; appropriate and adequate investments in public health; conducive referral and care coordination pathways; and instruments for community participation and inter-sectoral coordination among oth-

[1] Physician and health policy specialist, Mumbai, India. Email: soham.bhaduri@gmail.com

ers, apart from a political environment conducive to decentralized and participatory development. This paper reviews the policies, experiences, and historical development of some notable countries with respect to primary health care. Lessons that are broadly transposable to developing countries like India are derived, with particular emphasis on primary care manpower development, which has been a limiting factor in many countries.

Physician Power Dynamics

Japan has an advanced health system, having achieved UHC in 1961 and having among the highest life expectancies, lowest infant mortality rates, and lowest potential years of life lost among the OECD nations.[2] However, Japan doesn't stand out as a prominent proponent of primary health care in lacking many classical traits of a well-organized primary care system. Japan still maintains separate insurance programs and risk pools for different categories of its population (albeit with considerable cross-subsidization among them). It pays physicians predominantly through fee-for-service, whereby rates are negotiated biennially, unlike the capitation system prevalent in many primary care oriented systems. The health care delivery system remains fluid and dispersed, with health facilities of all sizes and scope providing a range of inpatient and outpatient services, often together. General practice isn't widely prevalent, patients have free access to all levels without a GP gatekeeper, and only recently has a limited referral system based on copayments been effected. It has been noted that deficient general practice is also responsible for the relatively poor quality of chronic disease care in Japan. The concept of primary care itself takes a very different form in Japan, with specialists in clinics delivering most primary care services. However, the typical physician manpower dynamics that transpired along the course of Japan's health system evolution makes it an interesting for countries struggling with a physician power imbalance skewed towards specialists.

The trajectory of Japan ushering into the era of modern medicine posited two conspicuous characteristics in its healthcare system: one, that hospitals shall not become the nucleus of healthcare delivery, and second, that its primary care practitioners shall possess enough leverage to influence how healthcare shall work. In Japan, hospitals, for the early part of their history with modern medicine, remained out of reach for the ordinary folk and catered mainly to the affluent class. This Japan owed to the fact that hospitals in Japan evolved, as Ikegami (2016) states, "as a workshop for physicians to treat patients by Western medicine, and not as charity organizations for the poor".[3] To the enormous costs that hospital care entailed, the Japanese government responded by actively reducing the funding of hospitals and restricting their function to training medical students, isolating those with communicable diseases, and treating combat-related injuries and diseases for the army and navy. Together with fewer hospital positions for specialists to assume, a status hierarchy among physicians based on the standing of the medical school from which they had graduated ensured that the vast majority of physicians, including specialists, had no other choice but to practice privately in clinics and deliver primary healthcare, with hospital positions being occupied by the so-called higher tier doctors. Once into private practice, these doctors could not establish gainful working connections with hospitals. While, on the one hand, this meant that a strong nexus between doctors in private clinics and hospitals, held together by common interests, could be thwarted; on the other hand, it meant that a sturdy lobby of clinic-based primary care practitioners could evolve to tip the balance in favour of primary healthcare. Japanese Social Health Insurance (SHI) implemented in 1927 came to cover blue-collar workers, a section that hospitals were scarcely interested in catering to, and the Japanese Medical Association (JMA), then dominated by clinic based physicians, was the main player in negotiating the fee schedule for the SHI. Not only did this cause the fee schedule to be weighted to primary healthcare services, but it also assured higher incomes for clinic based physicians as compared to hospital based physicians. Today, despite the number of hospital based physicians having risen manifold, the same trend persists, and clinic based physicians still preponderate in the JMA.

What makes the Japanese experience unique, despite not serving as an exemplar of an orderly primary care system, is that it managed to contain the clout of specialists from growing beyond bounds and accorded a prominent voice to its primary care practitioners in its decision making processes pertaining to healthcare. The same continues to be an intractable challenge for many developing and developed nations alike, resulting in reduced emphasis on disease prevention and health promotion, an overly hospital-oriented health system, overuse of sophisticated technologies, and high health expenditures with comparatively poorer outcomes.

Inculcating a Culture of Primary Care

Cuba is a Latin American nation that has for long been critically acclaimed for its well-performing primary health care system. The country has been hailed for achieving health indicators on par with developed nations at much lower levels of health spending, particularly low infant mortality, under-five mortality, low birth weight, and a high life expectancy.

Following the dethronement of the Batista Regime in 1959, Cuba witnessed tremendous disparities in terms of distribution of health infrastructure and manpower, with much of them being concentrated in urban centres, predominantly the capital Havana.[4] Similarly, poverty, illiteracy, and poor health indicators such as infant mortality (100 per 1000 live births) were significant challenges before the new-found state. Since the 1960s, Cuba began an ambitious drive to reform the health system, particularly to address the inadequacy of health facilities in rural areas. The Rural Medical Services (RMS) scheme was conceived to recruit freshly minted physicians in large numbers to rural areas, and alongside, rural hospital infrastructure was strengthened - from having just 1 rural hospital before independence to 53 hospitals in 1970.[5] In order to address long waiting times, short consultations, integrate preventive and curative care, ensure continuity and coordination of care, and to make healthcare available close to people, a network of Community Polyclinics (CP) were envisaged in 1974, which placed basic primary specialists, including Obstetricians/gynecologists, pediatricians, internists, surgeons, and even dentists in every Cuban community.[4] In 1983, the Family Physician and Nurse Program was rolled out to provide a primary health care team for every neighbourhood. These Family Physician-Nurse (FPN) teams would stay in the neighbourhood (often two storey buildings) they serve and prove basic curative, preventive, and curative health care services literally at the doorsteps, under the aegis of the community polyclinics, with around 15 FPN teams under each polyclinic. Each FPN team would cater to around 120-150 families in the neighbourhood. Services are arranged under two main processes embracing comprehensive preventive and clinical services (including home visits), and collection and reporting of important health and epidemiological data: namely, Neighbourhood Health Diagnosis and Continuous Assessment and Risk Evaluation.

This robust primary care system has been held to have delivered well, particularly in terms of maternal and child health and infectious diseases, and more recently, in cardiovascular disease and cancer control.[6] Notably, despite the US embargo and economic downturn following the collapse of the Soviet Union, health care remained a priority and expansion of family medicine services continued. However, probably the most unique and distinct lessons from the Cuban experience, at-least as far as establishing and sustaining a confirmed primary care workforce are concerned, lie in the medical education system of Cuba.

Following the transfer of responsibility for medical education to the Cuban ministry of Public Health in 1976, medical training was decentralized by establishing colleges in under-served areas, and students from rural areas were encouraged to enroll in medical schools and practise in their localities.[4] Also, the importance of inclusion of social determinants in the medical curriculum was appreciated early, in an attempt to create well-rounded physicians with both clinical and public health expertise. Epidemiology and public health in the medical syllabus were accentuated; learning in the community was fostered by making polyclinics and FPN clinics as training centres for medical students; and early inclusion of clinical skills with basic medical sciences. The typical culture and philosophy of medical education in Cuba can be considered the main factor facilitating measures like the famous Cuban "Medical Missions", as part of which thousands of Cuban physicians have been sent to under-resourced countries in more than 70 countries, including Africa and Latin America. By inculcating a deep community orientation and a flair for serving underserved communities, as well as reorienting the entire health system around primary care and triaging costly technology and advanced tertiary care, Cuba has been able to restrain one of the most intractable tendencies of modern physicians - that of excessive specialization. This has facilitated Cuban doctors and health care personnel to be employed and retained in diverse poor, under-resourced, and disaster-afflicted settings across low income countries, which is practically unthinkable for health workers from many other parts of the globe.

It has often been opined that although Cuba serves as an exemplar of primary health care, not many countries stand capable of replicating the Cuban experience. The early recognition of health as a right that is enshrined in the constitution; the entrenched socialized system of medicine; and a philosophy of medical care centred on serving the poor and under-served can be cited as the prime reasons for the same. Further, the authoritarian character of the Cuban government has

been held to have compelled many of these traits and measures, which is impractical for many democratic and liberal regimes. The Cuban health system and government in general have not been bereft of criticism. It has been contested that the pre-independence situation of widespread poverty, illiteracy, and poor health status has been overstated by the free government, and there have been recorded instances of people challenging the official version being incarcerated.[7] The Cuban Government's treatment of gays and HIV positive individuals has been widely criticized, the latter being confined to sanitariums until 1988 - and the labor rights disregard of doctors on foreign expeditions has been called into question, with the Cuban government sued for human trafficking in Brazilian courts. Nonetheless, the unpopular political aspects of the Cuban system make for an insufficient reason to disregard the many important lessons that it offers for low and middle income countries, particularly with respect to achieving good health at low cost and envisaging a health care workforce that is oriented to primary care, mainly through reforms in medical education and training.

Community Empowerment, Inter-sectoral Coordination, and Integrating Indigenous and Informal Providers

Thailand stands out as an example of a developing country that has achieved UHC at a fraction of the health spending incurred by many developed nations. In 2002, following the first general election under the new "people's constitution" of 1997, Thailand rolled out the universal coverage scheme (UCS), the third and final pillar of the Thai health insurance triad comprising of the UCS, the civil servants medical benefit scheme and the social security scheme for private and public formal sector employees.[8] The famous "triangle that moves the mountain" is often hailed as the policy process that made UHC possible, comprised of generation and management of technical capacity and knowledge; social movements and public support for healthcare expansion; and political will for UHC. These elements were connected by activist-physicians occupying high offices in the ministry. With the roll-out of the UCS, Thailand instituted two important changes: first, a contributory, voluntary social health insurance characterized by widespread adverse selection, insufficient coverage, and high administrative costs was converted into a universal tax-financed insurance scheme provisioned largely by public sector facilities; and second, a fee for service based system of paying physician consultations was converted into a capitation payment system that held down costs.[9]

Thailand's emphasis on primary health care, however, goes back far before the implementation of the UCS. Two such pilot projects focused primarily on strengthening community participation alongside improving health care capacity are particularly notable. In 1966, the Ministry of Public Health (MOPH) and the WHO together rolled out a project entitled "Strengthening of Rural Health" in the Pisanuloke province in the under-served North of Thailand.[10] Apart from capacity building of tambon and district level personnel, the programme aimed to train local volunteers in health. Similarly, in 1968, the *Saraphi* Project (named after a district in North Thailand) aimed at expanding the tambon and district level health care infrastructure and manpower along with fostering community participation. While both of these projects could register very little increase in service coverage, owing largely to inappropriate health personnel attitudes towards effective community participation, they provided an important lesson going forward: that people could be empowered to take care of not just their own but also their neighbor's health.

As part of the fourth national health development plan, 1977-81, Thailand rolled out a National PHC Programme aimed at increasing coverage of basic health services particularly in under-served rural areas, empowering communities to take care of their own health, and to promote health and integrate health data to reflect community needs. As part of the program, Village Health Communicators (VHC) were recruited and trained from their communities to serve various health promotion functions for a group of 8-15 households.[10] From among the VHCs, Village Health Volunteers (VHV) with additional training in curative health care were appointed. Both these cadres would work under government (provincial) system support to expand primary care services. The grass-roots cadres weren't only supposed to assist government health personnel in their activities, but were also expected to independently identify local problems, their solutions, and implement the latter with support from the government.

Another notable aspect of Thailand's PHC drive has been the campaign to empower villages, not just by training and empowering volunteers from villages but villagers themselves. Various community self-financing and management instruments were envisaged, and villages were empowered to plan and manage their own development with government sup-

port. As part of the "Technical Cooperation Among Developing Villages" initiative, well-performing villages were used as training centres for other villages in a bid to facilitate transfer of development knowledge between communities.[10] Thailand also revolutionized the training system, from a traditional top-down system where health system personnel would serve as trainers, to a decentralized system having villagers themselves as trainers. Apart from community participation, intersectoral collaboration has been an essential element of the Thai PHC drive, with participation from four major ministries including the MOPH, Ministry of Interior, education, and agriculture under initiatives like the "Basic Minimum Needs" approach, which aimed to holistically improve the minimum needs in addition to health at the community level and pursue related development targets by multiple ministries in unison.

The PHC initiatives of Thailand contributed significantly to improving indicators related to nutrition, access to clean water supply, immunization and vaccine preventable diseases, and provision of essential drugs.[10] Under the fifth development plan (1982-86), Thailand froze investments in urban hospitals and invested in strengthening rural hospitals, primary health facilities, and rural manpower. Such initiatives helped towards a crucial expansion of public health infrastructure that made UHC possible in further course, at a rather low spending. In terms of health human power policy too, Thailand's achievements have been notable. For instance, a few decades ago, Thailand faced a 21-fold gap in physician density between Bangkok and rural North-East regions, which reduced to 5 times by 2009, with the gap for nurses declining from 18-times to 3-times.[11] This was possible due to number of pecuniary and non-pecuniary incentives, including hardship allowances, overtime allowances, awards for best doctors and nurses, and others. While certain shortcomings persisted at each of these initiatives involving community participation and inter-sectoral collaboration, the fact that Thailand, a constitutional monarchy that has seen numerous military coups over the years, was able to pull-off these essentially democratically-rooted approaches to primary health care is in itself an achievement of a high order.

While Thailand is notable for training and empowering village level personnel, many examples exist of empowering informal or traditional practitioners to not just assist formal health care provision, as in Sri Lanka, but also to be absorbed into the mainstream formal health system. Japan made a point to integrate its indigenous practitioners into its organized healthcare as it gradually transitioned into modern medicine. At one point in its timeline, the Japanese government issued formal medical licenses to these indigenous practitioners so as to assure their livelihood, while following it up with a requirement for them to take regular courses and licensure exams so as to be fully integrated into the scheme of organized healthcare.[3] In China, the celebrated "barefoot doctors" of the 1960's and 70's later became village doctors who had to take regular exams and register with the local health bureau.[12] Although many of the foundational principles of the Barefoot Doctor initiative in China, including greater role of, and support from, the community, were undermined with the introduction of market principles later on - village doctors continued to be important elements of Chinese primary care system and have been popular with the public.

Role of Political Will, The Health Team Approach, and Dedicated Training in Family Medicine

Turkey has been popular for its pioneering Health Transformation Programme (HTP) of 2003 that produced considerably quick, wide, and deep reforms in health care organization, service provisioning, financing, and securing patients health's rights. The WHO summarized the Turkish experience in the following words: "it is possible to achieve major improvements in health system performance in a relatively short period of time under the right conditions".[13] The historical evolution of the Turkish health system that eventually led to the HTP demonstrates a continuing yet wavering tradition of political will for improving health. The 1990s saw a string of weak coalition governments with economic instability and few resolute improvements in health.[14] The 1999 Izmit earthquake exposed the their weakness and increased public expectation for robust health services, leading to a majority for the Justice and Development Party in the 2002 general elections, and eventually the HTP. Under the HTP, Turkey integrated the previously fragmented health insurance landscape into a Unified General Health Insurance Scheme; restructured the role of the Ministry of Health (MOH) from service provisioning to stewardship, delegating operational and purchasing responsibilities to other quasi-public agencies; increased health spending from 2.7% of GDP in 1990 to 6.1% of GDP in 2008, with public spending contributing 73% in 2008; increased public and private sector hospital beds, emergency ambulance and blood transfusion services; took a battery of measures to increase and redistribute health manpower; and implemented a number of health financ-

ing and governance reforms. One of the most popular elements, however, was the Family Medicine (FM) Reform of 2005 which revolutionized primary care organization and delivery.

Before the FM reform, Turkey had a 3-tier health care system: with health houses manned by midwives covering, serving 2000-2500 people; primary health centers at villages (5000-10000 population), districts (10000-30000 population), and provinces (30000-50000 population); and provincial health centres, Maternal and Child Health, Family Planning and tuberculosis centres.[14] Under the HTP, state contracted FM teams comprised of a medical doctor, nurse, and up to two medical assistants were made responsible for most of the primary care delivery, each team serving 1000-4000 population.[15] These teams also provide home care, mobile medical services, and visits to nursing homes, prisons, and child care centres.[14] To support better implementation of FM reform as well as for supervision and evaluation, field coordinator teams were employed to act as a link between the FM teams and the ministry, whose inputs helped in quickly appreciating and addressing ground-level challenges and implementational bottlenecks through continuous feedback and two-way communication.[16,14] A formal referral system was abolished in 2007, however, copayments were introduced for hospital care without referral from primary care.[17]

Turkey also took major steps to address human resource constraints and maldistribution. Apart from increasing the number of public medical school seats in primary care, Turkey initiated a retraining program for practising generalists and internists to be re-certified as FM physicians.[16] Medical school graduates are required to take state service, mostly into under-served rural areas for up to 500 days after graduation. FM physicians, in addition to their basic capitation payment, received additional remuneration for serving in under-served areas as well as performance incentives based on a number of quality measures, including antenatal care, immunization, and facility capacities. Alongside increasing provider remuneration in the public sector, measures were taken to make private practice less appealing. Dual practice by public sector doctors was banned in 2010, and new regulations to moderate the growth of the private sector were initiated in 2008.[14]

The HTP has shown remarkable improvement in Turkey's health indicators, particularly in MCH and infectious diseases control, and in reducing regional disparities in health outcomes. Infant mortality decreased by 65% between 2003 and 2010; under-five mortality declined 50% between 2000 and 2008; similar improvements were noted with respect to maternal mortality, skilled birth attendance, immunization, and out-of-pocket spending.[16] At the same time, both patient and physician satisfaction (with reduced physician absenteeism) were noted with the FM model. Increase in primary care utilization, a shift from secondary to primary care, and an increased preference for primary care over secondary care has also been noted.[17] Nonetheless, certain problems such as poor continuity of care due to weak electronic health systems and overworked family physicians persist.[16]

The Turkish experience of primary health care has been instructive in many ways: greater investments and incentives for primary care, conceiving primary care teams providing comprehensive care close to the community, continuous feedback and smooth redressal of ground-level issues, strong political will and public demand for primary health care, and others. However, the most prominent aspect has been the state-aided retention of health care staff in the public sector through strong and strategic policy instruments. As a matter of policy, private practice was made less attractive through better remuneration in the public sector, and a consequent shift of staff to the public sector made passing a law to ban dual practice easier. Concurrently, strong steps like mandatory government practice for fresh graduates were taken.

The Brazilian experience with primary health care is somewhat similar to that of Turkey. Health was recognized as a right in the Brazilian constitution in 1988.[18] The Family Health Strategy (FHS) for delivering integrated primary care close to the community began in 1994. Family Health teams comprised of a family physician, nurse, and about 6 Community Health Workers (CHW) serve a population of 3000 to 4000, with other professionals like psychologists, community pharmacists and physiotherapists for a group of four or five such teams.[19] Each CHW serves a maximum of 150 families, has minimum secondary education, and shoulder preventive, promotive, and some curative care responsibilities. As of 2016, nearly 265000 CHWs and 39905 teams covered around 2/3rd of the Brazilian population (mainly the low socioeconomic class and vulnerable) across 5477 out of 5770 of Brazil's municipalities. Until 2002, economic instability entailed that limited expansion of the FHS could take place. However, following the election of a left wing government and strong economic growth after 2003, invest-

ments in primary health care increased manifold, and minimum spending for all levels of government were set in law.[18] Primary care residency was expanded, full work week for primary care doctors was legislated,[19] and under the 2013 "More Doctors" program, 17000 Cuban doctors were recruited in Brazilian health care. However, the culture of specialization among doctors, leading to fewer graduates choosing to be generalists, has affected primary care physician supply.[19] Another challenge for the FHS has been the expansion of the program to middle- and upper socioeconomic classes.

The FHS served to improve health care access to low-income and vulnerable sections in Brazil. Improvements in avoidable hospitalizations, breastfeeding rates, immunization, and access to a regular source of care have been noted.[19] Data between 1990 and 2002 has shown a 10% increase in coverage to be associated with a 4.5% decline in infant mortality[20] Further, there has been increased public satisfaction and primary care utilization following introduction of the FHS.[21]

Similar to Turkey and Brazil, evidence from Lithuania[22] and Estonia[23] have also demonstrated increase in primary care service utilization following PHC reform which involved, among others, dedicated training of physicians in FM or general practice, whatever the nomenclature. For instance, a study by Liseckiene *et al*.[22] comparing the service profile of primary care physicians in Lithuania, between 1994 and 2004 (after retraining of therapists and pediatricians), found that in 2004, physicians had more office contacts with patients and exhibited stronger involvement in disease management. Higher patient satisfaction in multiple respects was noted among FM PHCs compared to non-FM PHCs in Egypt,[24] and similarly, in Thailand, greater patient satisfaction with regards to communication skills and patient enablement has been noted with doctors trained in FM than ones without a residency training.[25] This could be instructive for countries pursuing PHC reform, particularly those like India where basic MBBS doctors without further residency training have traditionally comprised the pool of primary care physicians, and where FM residency is a recent and weak accretion.

An Ecosystem Supportive of Primary Care

The health systems of the United Kingdom (UK) and the United States (US) are often presented as contrasting examples for countries pursuing health system reform. The United Kingdom is hailed for a strong public health system, the National Health Service (NHS); an effective primary care gatekeeper in the General Practitioner (GP); and traditionally low-powered payment systems such as capitation and salaries. On the other hand, certain aspects of the UK system such as overworked general practitioners, rationing of care and waiting lines, and lesser physician choice are criticized by many, particularly the proponents of the US health system. The US health system is hailed as one of the most advanced in the world, with ready availability of latest diagnostic and pharmaceutical technologies, cutting edge research in the biomedical sciences, and ready access to the choice physician or specialist. At the same time, the US health system is notorious for high and ineffectual health spending; comparatively poorer health outcomes, particularly in chronic diseases and obesity; inequitable economic access to healthcare; and a battery of fragmented, private health insurance schemes with little emphasis on primary care, although the latter has received renewed attention under the Affordable Care Act. Light[26] notes that many of the ills of the UK health system are attributable to insufficient spending, while that of the US lie in its poor design that fosters waste, inefficiency and inequity. Notwithstanding, another sharp contrast between the two nations exists in terms of their traditional approach to primary health care, which explains why the same thrived in the UK but largely failed in the US, any current or future reforms notwithstanding.

The UK's NHS, which was established in 1948 in response to the second world war, nationalized its hospitals which were hitherto largely public (under local bodies) and voluntary. However, the system of GPs being independent contractors largely persisted as before.[27] Under the NHS, each enrollee registers to a GP facility who acts as a gatekeeper to specialist services and is paid on a capitation basis. Specialist care, unless in emergencies, is available only on GP referral. Further, a number of measures to empower GPs were implemented over the decades, including turning them into fundholders who commission specialist care, collectively planning health services in their region, and others. Further, GP lifetime incomes were made equivalent to that of specialists, with added performance based incentives[26] and capitation carve-outs for certain preventive services. In the UK, a GP has to undergo specialist training in general practice after the basic medical degree.

Like in the UK, the US also requires basic physicians to undertake a residency in family medicine to practise as general practitioners (called family physicians in the US). However, the traditional approach in

the US has been that of a free medical market[28] offering undeterred access to a specialist without a GP gatekeeper, in line with the general ethos that emphasizes personal liberty. Unlike in the UK, where a tradition of general practice has traditionally been firmly rooted, family medicine in the US arose largely as a rather feeble counter-culture to hospital oriented, costly specialized care. In a setting of persistently increasing health care expenditures and the economic downturn around the 1970s, a movement favoring prevention and generalism grew and culminated in the 3-year family medicine program from an erstwhile 1-year general practice internship.[27] However, few systemic changes to support primary care were instituted. Specialists have always enjoyed a higher prestige and a higher pay than family physicians, as reflected in fewer emerging graduates opting for Family Medicine, and the much lesser share of GPs among doctors in the US than the UK. While it has been found that people in the US do prefer having a family physician, and that health outcomes are often better in areas supplied with better primary health care, most individuals prefer to maintain an undeterred access to their specialist.

The examples of the UK and US are greatly instructive for nations embarking on a primary health care reform.[29] In a free-market like health care system, primary care physicians fail to thrive on account of lesser prestige and pay than specialists, which when added to the natural tendency of physicians to specialize, impedes the development of a dedicated primary care physician workforce. Over time, the trajectories get reinforced due to path dependence and steering in a new direction becomes challenging. In addition to an emphasis of reforms in medical education, growth of generalism warrants a holistically supportive health system structure characterized by an incentive structure for people to seek primary care (through mechanisms like gate-keeping and copayments in the absence of referral) as well as reimburses generalists on attractive terms.

Conclusion

This review has brought out multiple lessons on effecting an enduring primary health care system, including those conditions which pertain to the broader ecosystem that it is a part of. These broadly include, among others, ensuring adequate representation for the primary care fraternity in health policy decisions and health system functioning; preventing the otherwise natural dominance of specialties and super-specialties through the right mix of incentives and disincentives guided by state policy; entrenching a medical educational system that is aligned to primary care, preventive and promotive health, and social determinants; actively empowering communities in health care planning, delivery, and management beyond the scope of training community health volunteers; ensuring effective inter-sectoral coordination among major ministries and departments; building a well-ordered and organized health system with a prominent role for the primary care practitioner (through mechanisms like gate-keeping), and providing incentives for patients to seek primary care; conceiving a health team-approach to primary care delivery incorporating physicians and allied health personnel, with well-defined pathways for referral and care coordination; conceiving mechanisms to integrate indigenous and informal practitioners based on context and assigning them appropriate primary care related responsibilities; additional and dedicated residency training for basic physicians in family medicine; and last but not the least, a strong political will and public demand for primary health care. It is important to note that some of these prerequisites may already be extant in certain countries pursuing primary health care reform, while some others may not be feasible or applicable for a given country's context. Neither are all of these necessarily important to be met under all circumstances. The right mix of these shall depend on the peculiarities, unique circumstances, and the requirements of the country context in question.

Talking specifically of human resources, it is important to build a bastion of primary health care in a dedicated group of primary care professionals, including doctors, who endeavor to keep their domain unscathed. Ikegami[13] suggests integrating unlicensed practitioners in exchange of adhering to basic regulations to enhance their accountability, which would increase the relative share of those providing primary health care and enhance their power. A dedicated and strong cadre of primary health care personnel can be the biggest proponents of a robust primary care system, and thus a crucial determinant of the success of primary care in a country.

References:

1. Rao M, Pilot E. The missing link--the role of primary care in global health. *Glob Health Action. 2014* Feb 13;7:23693.
2. Bhaduri SD. Japan: Health Care System Overview and SWOT Analysis. *The Indian Practitioner. 2021*;74(1):29-32.
3. Ikegami N. Achieving Universal Health Coverage by Focusing on Primary Care in Japan: Lessons for Low- and Middle-Income Countries. *Int J Health Policy Manag. 2016*

Feb 25;5(5):291-3.

4. Keck CW, Reed GA. The curious case of Cuba. *Am J Public Health. 2012* Aug;102(8):e13-22.
5. Garcia GD. El servicio médico rural en Cuba: ante-cedentes y desarrollo histórico, Cuadernos de la Historia de la Salud Pública #72. Havana, Cuba: Ministry of Public Health; 2018.
6. Cooper RS, Kennelly JF, Orduñez-Garcia P. Health in Cuba. *Int J Epidemiol. 2006* Aug;35(4):817-24.
7. Gómez Dantés O. The Dark Side of Cuba's Health System: Free Speech, Rights of Patients and Labor Rights of Physicians. *Health Syst Reform. 2018*;4(3):175-182.
8. Thaiprayoon S, Wibulpolprasert S. Political and policy lessons from Thailand's UHC experience. ORF Issue Brief. 174; 2002.
9. Tangcharoensathien V, Patcharanarumol W, Ir P, Aljunid SM, Mukti AG, Akkhavong K, Banzon E, Huong DB, Thabrany H, Mills A. Health-financing reforms in southeast Asia: challenges in achieving universal coverage. *Lancet. 2011* Mar 5;377(9768):863-73.
10. Nitayarumphong S. Evolution of primary health care in Thailand: what policies worked? *Health Policy and Planning. 1990* Sep;5(3):246–254.
11. Tangcharoensathien V, Limwattananon S, Suphanchaimat R, Patcharanarumol W, Sawaengdee K, Putthasri W. Health workforce contributions to health system development: a platform for universal health coverage. *Bulletin of the World Health Organization. 2013*;91(11):874–880.
12. Bloom G. Universal Health Coverage and Primary Healthcare: Lessons From Japan Comment on "Achieving Universal Health Coverage by Focusing on Primary Care in Japan: Lessons for Low- and Middle-Income Countries". *Int J Health Policy Manag. 2017* Apr 1;6(4):229-231.
13. World Health Organization. Successful Health System Reforms: The Case of Turkey. WHO Regional Office for Europe. 2012 May.
14. Atun R, Aydın S, Chakraborty S, Sümer S, Aran M, Gürol I, Nazlıoğlu S, Ozgülcü S, Aydoğan U, Ayar B, Dilmen U, Akdağ R. Universal health coverage in Turkey: enhancement of equity. *Lancet. 2013* Jul 6;382(9886):65-99.
15. Sumer S. Case study for People Centered Health Care in Turkey Final Report. World Bank. 2015.
16. PHCPI [Internet]. Turkey: Greater availability of primary care services results in high patient and physician satisfaction. [Cited 2021 April 25].Available at: https://improving-phc.org/promising-practices/turkey.
17. Hone T, Gurol-Urganci I, Millett C, Başara B, Akdağ R, Atun R. Effect of primary health care reforms in Turkey on health service utilization and user satisfaction. *Health Policy Plan. 2017* Feb;32(1):57-67.
18. Massuda A, Hone T, Leles FAG, de Castro MC, Atun R. The Brazilian health system at crossroads: progress, crisis and resilience. *BMJ Glob Health. 2018* Jul 3;3(4):e000829.
19. Wadge H, Bhatti Y, Carter A, Harris M, Parston G, Darzi A. Brazil's Family Health Strategy: Using Community Health Workers to Provide Primary Care. The Commonwealth Fund. 2016. Available from: https://www.commonwealthfund.org/publications/case-study/2016/dec/brazils-family-health-strategy-using-community-health-care-workers#:~:text=Brazil%2C%20the%20world's%20fifth%2Dlargest,nurses%20or%20physicians%2C%20and%20collect
20. Macinko J, Guanais FC, de Fátima M, de Souza M. Evaluation of the impact of the Family Health Program on infant mortality in Brazil, 1990-2002. *J Epidemiol Community Health. 2006* Jan;60(1):13-9.
21. Rocha R, Soares RR. Evaluating the impact of community-based health interventions: evidence from Brazil's Family Health Program. *Health Econ. 2010* Sep;19 Suppl:126-58.
22. Liseckiene I, Boerma WG, Milasauskiene Z, Valius L, Miseviciene I, Groenewegen PP. Primary care in a post-communist country 10 years later Comparison of service profiles of Lithuanian primary care physicians in 1994 and GPs in 2004.
23. Atun RA, Menabde N, Saluvere K, Jesse M, Habicht J. Introducing a complex health innovation--primary health care reforms in Estonia (multimethods evaluation). *Health Policy. 2006* Nov;79(1):79-91.
24. Gadallah MA, Allam MF, Ahmed AM, El-Shabrawy EM. Are patients and healthcare providers satisfied with health sector reform implemented in family health centres? *Qual Saf Health Care. 2010* Dec;19(6):e4.
25. Jaturapatporn D, Dellow A. Does Family Medicine training in Thailand affect patient satisfaction with primary care doctors? *BMC Fam Pract. 2007* Mar 29;8:14.
26. Light DW. Universal health care: lessons from the British experience. *Am J Public Health. 2003* Jan;93(1):25-30.
27. Bodenheimer TS, Grumbach K. Understanding health policy: a clinical approach. 5th ed. McGraw-Hill; 2008.
28. Stevens RA. The Americanization of family medicine: contradictions, challenges, and change, 1969-2000. *Fam Med. 2001* Apr;33(4):232-43.
29. Banerjee A. Family medicine in India: Losing the way in spite of the map. *Medical Journal of Dr. DY Patil University. 2016*;9:1-3.

+