**Implementing primary health care policy under changing global political conditions: lessons learned from four national settings**

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Health systems struggle with equitable and affordable health spending.1 Over-medication, low-value care,2 poor access and social determinants of health3 amplify inequity. At the same time, primary health care (PHC) improves efficiency, equity, effectiveness,4 5 and population health.6-8 Community-based person- and population-centered care9 10 reduces health inequalities. This requires ongoing policy. This paper explores how to secure long-term PHC policies, from policy makers obsessed with ‘quick wins’.

**Appealing to policy makers**

Investment in PHC reduces inefficiency and/or overall costs. studies reported a 43% increase in PHC spending resulted in a 14% reduction in total health spending;11 yielded a 13-fold return on this investment;12 and improved the effectiveness and efficiency of the health system.13 Yet, this does not guarantee policy makers’ commitment.14 Too often, experiments are prematurely abandoned: for example in Brazil, where PHC was associated with reduced hospitalization;15 or in the US, where PHC reduced costs and hospitalizations but rapid consolidation of PHC policy restricted comprehensiveness.16-18

Social inequities affect a range outcomes from life expectancy, crime, education to mental health.19-21 Greater equality has the strongest impact for the poorest, but also benefits those socio-economically well-off:20 3 21 22 This should encourage policymakers to address social determinants of health,3 21 through PHC, as an affordable, politiocally-attractive solution.23 In this context, experiences from the UK, Canada, Mexico and the US are presented.

**Experiences**

***England***

A crisis in general practice, caused by an increased workload, poor recruitment and mounting early retirement, was the ‘tipping point’ for major policy changes.24 A report was commissioned that contained 38 mainly uncontentious, already earlier argued-for recommendations.25 This resulted in the adoption of major increases in funding and staffing26 see box 1. It took a developing crisis and professional consensus about what needed to be done to produce action by government.

***Canada***

Canada’s primary care physician shortage and poor rankings on international comparisons27 persuaded policy makers to invest in PHC. Transformation of the health system was done with emphasis on PHC payment reforms, inter-professional teams, after-hours access, electronic health record systems, regionalization, and development of clinical networks.28 This increased the PHC workforce, including many non-physicians. Pilot projects and local initiatives improved outcomes,29 but had limited scale and impact.30 31 This restricted PHC’s contribution to population health, patient experience and costs32 – due to continued fee-for-service payments, and poor integration with social and community sectors and hospital care.

***Mexico***

The Mexican health system remains fragmented and universal coverage for PHC is not (yet) achieved.33 Although it is argued that PHC is at the center of the system, and family medicine specialization was introduced in 1971,34 pervasive inequalities persist. Main advances have been seen in reduced infant mortality and increased health promotion. In 2004 further PHC innovations were installed,34 but lacked continuity of policy support for success. Population demographics (46% are under the age of 25 years),35 remains a challenge. With uncertain commitment of politicians, insurers and educators, advocacy of the role of PHC and patients’ experiences is a priority.33 36

***US***

International comparisons of countries and health systems37 were important to support US policy-makers in health reforms.38 39 40 Following this, experts from Australia, Denmark, the Netherlands, New Zealand addressed key US policy makers about innovations in their countries: the *Embassy Conversation Series*. US responders translated this evidence from other countries into implications for the US. After summary presentations in the US Congress a $1billion support for research and demonstration projects was provided under the Affordable Care Act.41-43 A U.S. – Canada *Cross-National Implementation Science Symposium* canvassed best practices in addressing multimorbidity, alternative payment models, and health equity. The lessons that could be learned were ‘translated’ to the US context.

***International comparisons***

Against these experiences findings from other, developed and mainly developing, countries were placed.14 44 45 33 46 In general, PHC was associated with improved efficiency, access and equity. Lessons learned were the need of consistent PHC policy over time that includes regulations on professional training, and on access to practice, while pursuit of universal health coverage creates opportunities for PHC.

**Conclusions**

From this, it is recommended to:

* make sure that policymakers understand the benefits of PHC, and *how* it improves individuals’ and populations’ health.
* seize moments of crises in health systems to promote PHC.
* connect PHC implementation with the WHO’s universal health coverage agenda.
* engage with community leaders, policy makers and other stakeholders in driving reforms and innovations.
* emphasize that the whole of society benefits from PHC, not only the marginalized or wealthy.
* Stress that PHC development is a continuous and not a one-off process of meeting evolving needs of populations.

**References**

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Box 1

Additional £2.4bn per annum into general practice by 2020/21, including £900m capital investment

Additional help for GPs with indemnity costs

Immediate £500m to support struggling practices

5000 more GPs in England by 2020 (reinforcement of a previous commitment)

1500 pharmacists working in general practices by 2020

3000 mental health therapists in general practices by 2020

1000 physician associates in general practice by 2020

Training of administrative staff and piloting new ‘medical assistant’ role to reduce GPs paperwork

Hospitals required to send electronic discharge summaries within 24 hours (by 2016), electronic letters within 24 hours of outpatient appointments (by 2018), patients and GPs to be notified of hospital test results, measures to reduce unnecessary GP workload created by hospitals

Reduced bureaucracy and inspections

£16m in specialist mental health services for GPs suffering from burnout and stress

*Box 1: Headline proposals in NHS England’s ‘General Practice Forward View’*

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