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ON PRIMARY HEALTH CARE

Building the **economic case for primary health care**: a scoping review

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Abbreviations

CHW	community health worker
HIC	high-income countries
LMIC	low- and middle-income countries
PCP	primary care physician
PHC	primary health care
UN	United Nations
WHO	World Health Organization

Executive summary

Powerful evidence suggests that primary health care (PHC), particularly primary care, can produce a range of economic benefits through its potential to improve health outcomes, health system efficiency and health equity. This is demonstrated in a conceptual framework in Fig.3, and summarized below:

- Health outcomes – primary care can improve population health in terms of life expectancy, all-cause mortality, maternal, infant and neonatal mortality as well as mental health outcomes.
- Health system efficiency – primary care can reduce total hospitalizations, avoidable admissions, and emergency admissions and hospitalizations.
- Health equity – primary care improves equitable access to health care and equitable health outcomes.

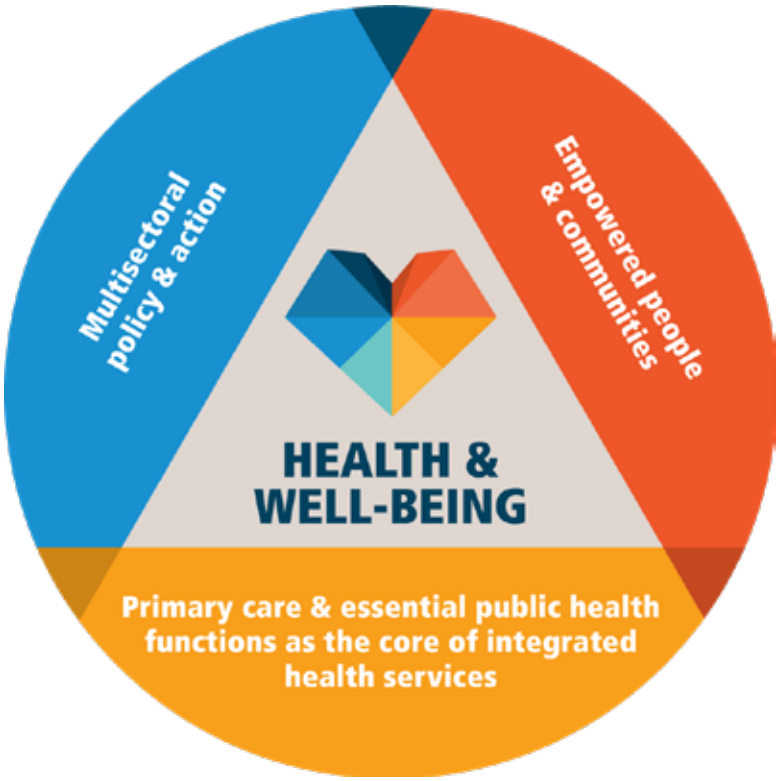
Despite these benefits, internationally, PHC is prioritized to varying degrees. This document reviews the evidence for the economic benefits of PHC, but there remains a need to further develop the economic case for increased investment in PHC. Research is needed to characterize which aspects of primary care and PHC have the greatest potential to improve health outcomes, health system efficiency and health equity, thereby maximizing the potential economic benefits; and to identify the barriers and enablers to implementation. Such research will provide a roadmap for strengthening PHC systems and allow policy-makers to target investments.

Introduction

The term "primary health care" (PHC) first emerged in the United Kingdom in the 1920s with the publication of a government white paper, the "Dawson Report". The report suggested that PHC centres would become the model for providing community health care services as a strategy to address health inequalities and respond to the increasing complexity of health care delivery *(1)*. Over the following decades, the concept of PHC developed significantly, culminating in the 1978 Alma-Ata Declaration, which defined PHC as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford" *(2)*.

Now, 40 years later, the Global Conference on Primary Health Care reaffirms the global commitment to PHC, as a key strategy to achieve universal health coverage and the United Nations (UN) Sustainable Development Goals (SDGs) *(3)*. To date, the implementation of PHC internationally has been limited by the lack of a universally accepted definition. The background paper for the Global Conference on Primary Health Care, A vision for primary health care in the 21st century, aims to resolve this issue by describing PHC as whole-of-society approach to health, based on three interrelated and synergistic components (Fig. 1).

Fig. 1. Conceptual framework of PHC



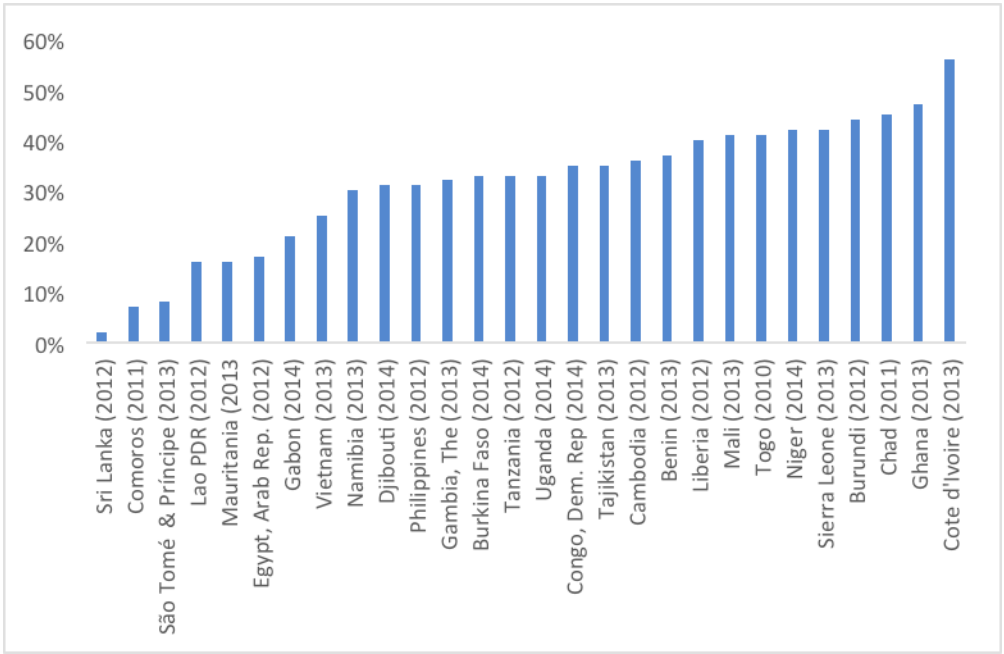
Source: A vision for PHC in the 21st century: toward universal health coverage and the Sustainable Development Goals (Draft 4 September 2018, WHO).

The first of these pillars, "Health services" includes the delivery of quality multidisciplinary primary care and essential public health functions. The second, "Multisectoral policy and action", encompasses policies and action across governments, ministries, nongovernmental organizations and the private sector that address the social, economic, environmental and commercial determinants of health. The third, "Empowered people and communities", describes how people should be empowered to optimize their health, both in terms of self-care and as informal care givers, and as engaged communities, whereby people are active partners and actors in health services.

The delivery of primary care can be understood as the delivery of five key concepts of primary care: providing first contact of care for new health problems, comprehensive care for most health problems, continuity of care, long-term person-focused care and care coordination *(4)*. The public health functions specifically relevant to a PHC approach and closely linked to primary care are health promotion, health protection, and disease prevention (service delivery), surveillance and response, and emergency preparedness (intelligence) *(5)*.

Despite significant evidence linking PHC to improved health outcomes, health system efficiency and health equity *(6)*, the degree to which health systems and societies align with PHC varies considerably across countries *(7)*. For example, the percentage of government spending dedicated to PHC is estimated to vary between 2% and 56% across a range of low- and middle-income countries (LMIC) [1] (Fig. 2). In the context of competing demands for limited resources, building the economic case for PHC is essential in order to convince policy-makers to increase investment in PHC. Hence, this paper describes the outcomes of a scoping review via a conceptual framework, to explore multiple pathways through which PHC can be linked to economic benefit.

Fig. 2. Percentage of current government health spending dedicated to PHC



Adapted from PHCPI *(8)*.

[1] Data was collected by PHCPI team using the System of Health Accounts (SHA) 2011 standards, which were jointly developed by WHO, the Organisation for Economic Co-operation and Development (OECD) and the United States Agency for International Development (USAID). A working definition for PHC expenditure has been developed that includes all expenditures for providers who only provide PHC services, expenditures for PHC preventive services provided by additional providers, a proportion of overall capital costs, and a proportion of administrative expenditures.

What do we know about the economic benefits of PHC?

To date, our knowledge of the economic benefits of PHC has been hampered by methodological constraints. Measuring the strength and quality of PHC is difficult because of a lack of unified definitions and data requirements. Also, the impact of PHC is broad and is interrelated with other sectors, which leads to significant uncertainty when attempting to quantify the benefit.

Nevertheless, some international studies have analysed the strength of PHC-orientation in health systems, which has led to mixed conclusions *(9,10).* Most of the data we have on the economic impact of PHC reflect the health services component. An international study comparing the strength of primary care in 13 high-income countries (HICs) found that strong primary care led to improved population health and lower health expenditure *(9).* A later study that compared the strength of primary care in 31 European countries used an alternative definition; it found that stronger primary care is linked to better population health, but also to higher overall health expenditure *(10).*

Beyond these studies, most of what we can deduce about the economic benefits of PHC is derived from measurable outcomes such as mortality, hospital admissions and health care costs. For example, there is evidence that increased investment in primary care can reduce use of secondary care and reduce overall health costs *(4,6,11–14).* Also, growing evidence demonstrates that primary care can improve population health in terms of life expectancy, all-cause mortality, and maternal, infant and neonatal mortality *(4,15,16).* More specifically, evidence shows that, compared with subspecialists, primary care physicians (PCPs) use fewer resources in terms of hospitalizations, prescriptions and common tests and procedures (*17,18).* Further, the return on investment from community health workers (CHWs) has been estimated as $10 for every $1 spent in sub-Saharan Africa *(19).* In addition, there is compelling evidence of significant economic benefit from the provision of preventive services in PHC; for example, the return on investment from childhood immunizations in LMIC has been estimated as $44 for each $1 spent *(20).* With such a breadth of evidence, a collective review of the potential economic benefits of PHC across multiple pathways, with the evidence summarized, is required.

Objective

The objective of this document is to summarize the results of a scoping review of literature in order to build the economic case for increased investment in PHC, using a conceptual framework. This document does not aim to provide a summary of the economic benefits of individual interventions within PHC; rather, it aims to review the economic benefits of PHC more generally. This document offers an introduction to the economic benefits of PHC, which may influence further work in specific areas of PHC delivery.

Why a scoping review?

Scoping reviews aim to rapidly map the key concepts and main types of evidence underpinning a research area. They are often used in complex areas, or in areas that have not been researched comprehensively *(21).* In contrast, systematic reviews focus on a well-defined question for which appropriate study designs can be identified in advance. Scoping reviews are performed, for example, to examine the extent, range and nature of research activity; to determine the value of undertaking a full systematic review; to summarize and disseminate research findings; and to identify research gaps in the existing literature *(22).*

As noted, a wealth of evidence suggests a link between PHC and other measures such as health outcomes, use of secondary care and reduced health care costs, although the evidence linking PHC to economic benefit is limited. The definitions of PHC and primary care vary, as do the many potential pathways linking PHC to economic benefits. These pathways are complex, ill-defined and multifactorial. Therefore, it is not possible to neatly define this research question or appropriate study designs. Undertaking an initial scoping review can help

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