Political economy dichotomy in primary health care: bridging the gap between reality and necessity

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Recent evidence synthesized in the WHO Global Report on Primary Health Care (PHC)[1] reiterates the case for prioritizing PHC in health and health systems with evidence clearly showing that long-term benefits of reorienting health towards PHC outweigh the costs (see Box 1).

Yet, political commitment for investing in PHC wavers. Why?

One major overlooked reason is the persistent political economy dichotomy between where the investment is done and where it is actually needed. By shedding light on these dichotomies, we hope to equip policy-makers with the understanding needed to address them and thus firmly establish health systems on the foundations of PHC.

The first dichotomy lies in the political and financial prioritization of specialist care and hospital services despite the overwhelming population need and policy emphasis on front-line community care, for which generalist skills are crucial.

In many countries, insufficient investment in PHC has created a detrimental cycle. This cycle involves under-resourced front-line services provided by health workers who may not have received adequate training as generalists. As a result, public trust has been eroded, leading to underutilization of primary care and further reinforcing the undervaluing of PHC. Unfortunately, the medical community and the wider population often associate high-quality care with specialized, technology-intensive, hospital-based services. Consequently, the training of generalist physicians, nurse practitioners, community health workers, and other allied health professionals, who primarily work in primary care, continues to suffer from persistently low investment. While both generalist and specialist care are essential components of the PHC agenda, the current strong bias towards specialized care poses a significant problem.

The second dichotomy relates to investments that take pro-poor approaches for primary health care, aiming to reduce poverty-related disparities. However, an emphasis on "the poor" has contributed to a distorted perception of PHC as inferior care for impoverished individuals or low-income areas. This is beginning to give way to *proportionate universalism* which aims to address the health needs of the entire population, while also tailoring the scale and intensity of support provided in proportion to the disadvantage people experience.

PHC's association with poverty, but also with generalist care which is not 'high-tech' and not provided by those who have 'more' or 'better' specialist training, has cemented the perception of PHC somehow being 'not as good', making it difficult for governments to convince health stakeholders to move resources to PHC.

Finally, the prioritization of vertical approaches to health service delivery, which focuses on specific conditions or subpopulations (e.g., diabetes control program or maternal and child health program), has hindered investment in PHC, particularly in lower-income countries. This preference for vertical approaches over more integrated, horizontal approaches, which aim to address the comprehensive needs of individuals across various services, has limited assertive investment in PHC. It is crucial to prioritize investments in horizontal approaches, such as strengthening comprehensive PHC centers that cover a full range of health services including child health, maternal health, mental health, chronic disease care, and more. Convincing development aid agencies (examples are GIZ, USAID, and AFD) to support a unified PHC-oriented health strategy remains challenging, especially in donor-dependent settings. Historically, private philanthropists, international donors, and national governments have favored verticalism due to its perceived ease of understanding, implementation, and tangible outcomes, particularly during times of crisis and

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Box 1.

The evidence shows that the long-term benefits of reorienting health towards PHC outweigh the costs.

PHC makes care more efficient and equitable, reducing the use of specialists and hospital services[2,3] by ensuring continuity, defined as ongoing relationships between physicians and patients, and fostering more appropriate use of care and lower health care costs.[4,5]

PHC improves access to quality services supporting continuity, comprehensiveness and coordination despite the heterogeneous impacts of PHC in different settings, provided that it is enabled by financing strategies, workforce development and community engagement.[6]

PHC improves population health in the long-term, supporting better health outcomes including for mental and child health and noncommunicable diseases.[7,8]

PHC contributes to higher user satisfaction and better self-reported health by providing care in a trusted setting where the patient, family and community contexts are understood.[9]

PHC reinforces emergency preparedness and resilience through prevention, bridging individual and population-level perspectives, its multidisciplinary approach, and the ties it creates with and within communities.[10]

austerity. Achieving a robust PHC-rooted health system requires a careful balance between vertical and horizontal approaches.

Policy-makers require a deeper comprehension of these challenges and underlying dichotomy in order to bridge the gap during windows of political opportunity between the reality of where health investments go and where the health need is. It is during these opportune moments that one can more easily address the positions and interests of those who benefit from the status quo. In the meantime, we must invest heavily in known technical solutions such as publicly funding comprehensive PHC services, including medicines; investing in high-quality general practice including nursing; raising awareness of PHC's importance in the medical community and across the population; integrating primary care and public health; investing in data to drive performance; and bringing services closer to people through digital means, domiciliary care and self-care. These solutions aim to make PHC responsive and high-quality so that people trust it to become the true interface between their lives and the wider health system.

Contributors

DR conceptualized the manuscript, wrote the first draft, coordinated the input of all authors, and revised the first to the final draft. MJ, GS, NA-M, and JW provided overall substantive input to the manuscript. DP, EdR, TN, AGJ, TT, and NG provided substantive input to specific sections of the manuscript. SL, FK, SD, and JF reviewed all drafts, and provided substantive input to them.

Declaration of interests

No declaration of competing interests.

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