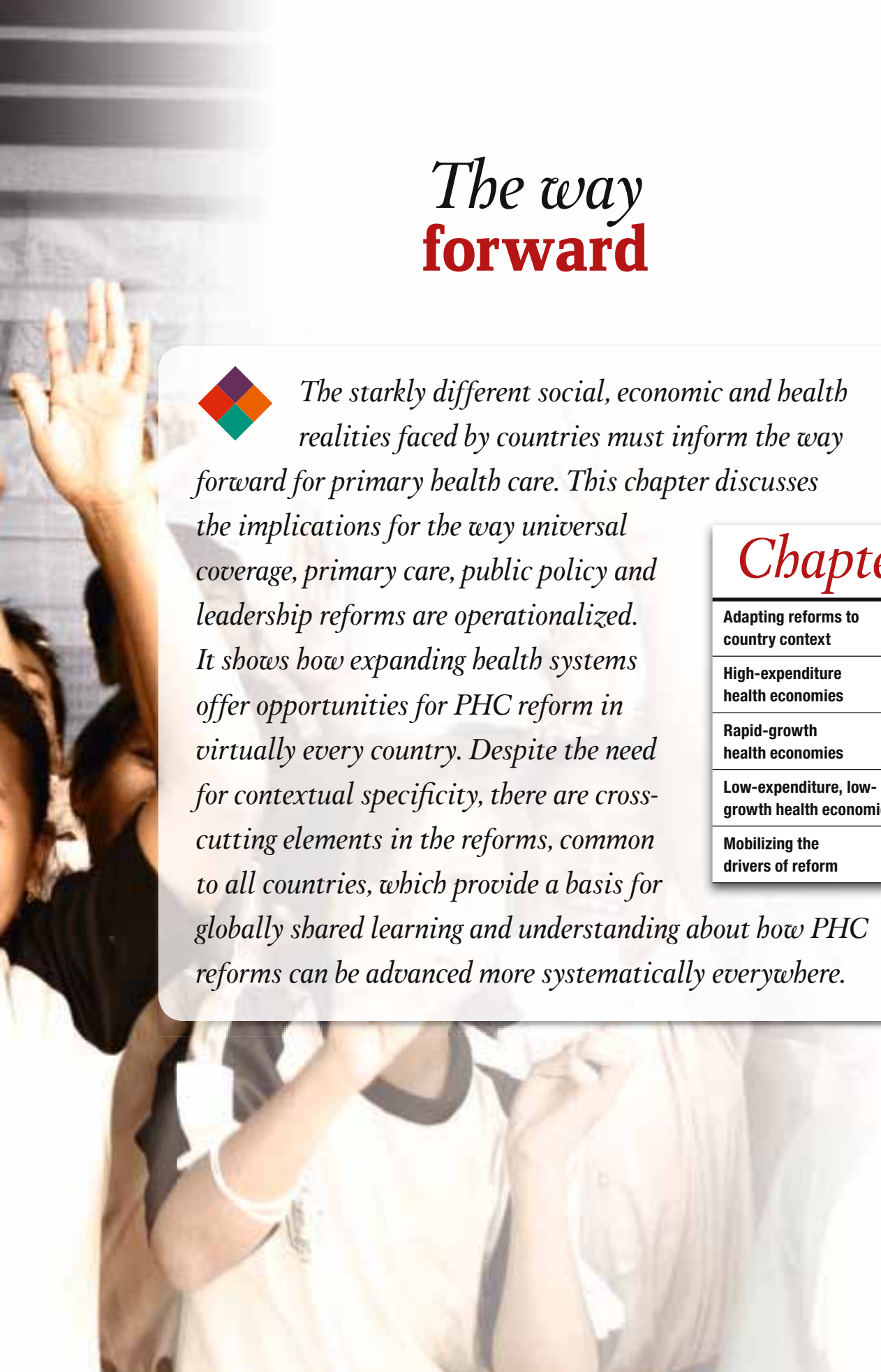


The way **forward**

The starkly different social, economic and health realities faced by countries must inform the way forward for primary health care. This chapter discusses the implications for the way universal coverage, primary care, public policy and leadership reforms are operationalized. It shows how expanding health systems offer opportunities for PHC reform in virtually every country. Despite the need for contextual specificity, there are cross-cutting elements in the reforms, common to all countries, which provide a basis for globally shared learning and understanding about how PHC reforms can be advanced more systematically everywhere.

Chapter 6

Adapting reforms to country context

Although insufficiently acknowledged, the PHC movement has been a critical success in that it has contributed to the recognition of the social value of health systems, which has now taken hold in most countries in the world. This change of mindset has created a radically different health-policy landscape.

Present-day health systems are a patchwork of components, many of which may be far removed from the goals set out 30 years ago. These same health systems are converging. Driven by the demographic, financial and social pressures of modernization, they increasingly share the aims of improved health equity, people-centred care, and a better protection of the health of their populations.

However, that does not mean that health systems across the world will change overnight. Reorienting a health system is a long-term process, if only because of the long time lag to restructure the workforce[1] and because of the enormous inertia stemming from misaligned financial incentives and inadequate payment systems[2]. Given the countervailing forces and vested interests that drive health systems away from PHC values, reform requires a clear vision for the future. Many countries have understood this and are developing their strategic vision of public policies for health with a perspective of 10 to 20 years.

These visions are often couched in technical terms and are highly vulnerable to electoral cycles. Nevertheless, they are also increasingly driven by what people expect their health authorities to do: secure their health and improve access to care, protect them against catastrophic expenditure and financial exploitation, and guarantee an equitable distribution of resources[3,4]. As shown throughout this Report, the pressure that stems from these value-based expectations, if used resolutely, can ensure that the vision is not deflected and safeguard it from capture by short-term vested interests or changes in political leadership.

The protection this offers is greatly reinforced by early implementation. The possibilities to start effecting change as of now exist in virtually all countries: the growth of the health sector provides financial leverage to do so, and globalization is offering some unprecedented opportunities to make use of that leverage.

This does not in any way diminish the need to recognize the widely divergent contexts in which countries find themselves today: the nature of the health challenges they face and their wider socioeconomic reality; and the degree of adaptation to challenges, the level of development and speed at which their health systems expand.

Opportunity for change is largely related to the flow of new resources into the health sector. Across the world, expenditure on health is growing: between 1995 and 2005, it almost doubled from I$ 2.6 to I$ 5.1 trillion. The rate of growth is accelerating: between 2000 and 2005, the total amount spent on health in the world increased by I$ 330 billion on average each year, against an average of I$ 197 billion in each of the five previous years. Health expenditure is growing faster than GDP and faster than population growth. The net result is that, with some exceptions, health spending per capita grows at a rate of more than 5% per year throughout the world.

This common trend in the growth in health expenditure masks a greater than 300-fold variation across countries in per capita expenditure, which ranges from less than I$ 20 per capita to well over I$ 6 000. These disparities stratify countries into three categories: high-expenditure health economies, rapid-growth health economies, and low-expenditure, low-growth health economies.

The high-expenditure health economies, not surprisingly, are those of the nearly 1 billion people living in high-income countries. In 2005, these countries spent on average I$ 3752 per capita on health, I$ 1563 per capita more than in 1995: a growth rate of 5.5% per year.

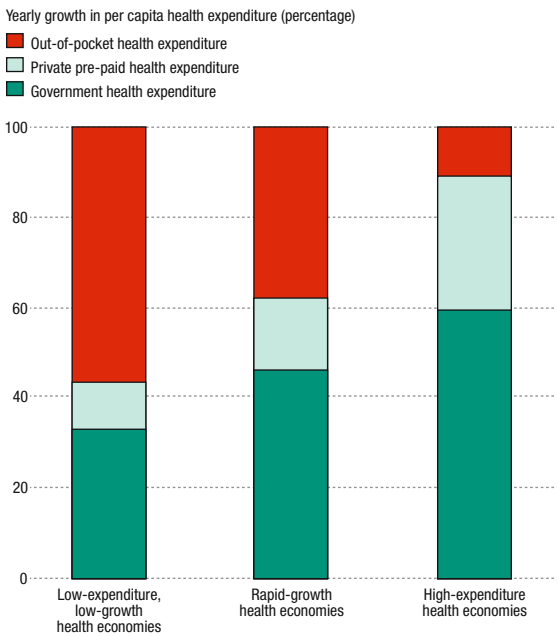
At the other extreme is a group of low-expenditure, low-growth health economies: low-income countries in Africa and South- and South-East Asia, as well as fragile states. They total 2.6 billion inhabitants who spent a mere I$ 103 per capita on health in 2005, against I$ 58 in 1995. In relative terms, these countries have seen their health expenditure per capita grow at roughly the

same rate as high-expenditure countries: 5.8% each year since 1995, but, in absolute terms, the growth has been disappointingly low.

In between those two groups are the other low- and middle-income countries, those with rapid-growth health economies. The 2.9 billion inhabitants in these countries spent an average of I$ 413 per capita in 2005, more that double the I$ 189 per capita that they spent in 1995. Health expenditure in these countries has been growing at a rate of 8.1% per year.

These groups differ not only in the rate and size of their growth in health expenditure. A breakdown according to the source of growth reveals strikingly different patterns (Figure 6.1). In the low-expenditure, low-growth health economies, out-of-pocket payments account for the largest share of the growth, while in rapid-growth and high-expenditure health economies, increased government expenditure and pre-payment mechanisms dominate. Where growth in health expenditure is through pre-payment mechanisms, there is greater opportunity to support PHC reforms: collectively pooled monies are more readily re-allocated towards interventions that provide a larger health return on investment than out-of-pocket payments. Conversely, countries where growth is primarily through out-of-pocket expenditures have less leverage to support PHC reforms. Alarmingly, it is in countries where expenditure is the lowest and the burden of disease highest that there is a real lack of opportunities for harnessing the growth of their health sector for PHC reforms.

Figure 6.1 Contribution of general government, private pre-paid and private out-of-pocket expenditure to the yearly growth in total health expenditure per capita, percentage, weighted averages[5]



The following sections outline broad categories of contexts that can shape responses for PHC reforms.

High-expenditure health economies

This group of countries funds almost 90% of its growth in health expenditure – an extra I$ 200 per capita per year in recent years – through increased government and private pre-payment funds. Expanding or changing the offer of services in these countries is less constrained by finances than by the relative lack of human resources to meet rising and changing demand. Their health systems are built around a strong and prestigious tertiary care sector that is important to the heavyweights of the pharmaceutical and medical supply industries[2]. Out-of-pocket payments, though still significant at 15% of total expenditure, have been dwarfed by more progressive collective means of financing. The third-party payment institutions have, thus, become central actors while the long-standing autonomy of the health professionals is waning. Efforts to control costs, improve quality and access to disadvantaged groups have given rise to a widening public debate on which users and special interest groups have increasing influence. Nevertheless, the state carries more weight in the health sector of these countries than ever before, with increasingly sophisticated regulatory tools and institutions.

Despite worries over their long-term sustainability, the solidarity mechanisms that finance these health systems enjoy considerable social consensus. The secular trend towards extension of coverage to all citizens, and, often reluctantly, to non-citizen residents as well, continues. In the state of Massachusetts, the United States, for example, the 2006 health insurance bill aims at 99% coverage by 2010. At the same time, it is becoming increasingly clear that universal

coverage schemes need to be complemented by efforts: (i) to identify those who are excluded and set up specifically tailored programmes to include them; and (ii) to tackle the social determinants of health inequalities through policy initiatives that cut across a large number of sectors (Box 6.1), so as to translate the political commitment to health equity into concrete advances.

In many of these countries, the shift in point of gravity from tertiary and specialized care to primary care is well under way. Better information and technological developments are creating new opportunities – and a market – for moving much of the traditionally hospital-based care into local services staffed by primary-care teams or even into the hands of patients themselves. This is fuelling a change in perception of how health services should operate. It provides support for primary care, including self-care and home care. Movement in this direction, however, is held up by inertial forces stemming from the threat of downsizing and dismantling massive tertiary-care facilities and from demand induced by the illusion that the extension of life through technology is unlimited[7]. Technological innovation is indeed a driver of improvement and current trends show that it is expanding the range of services offered by primary-care teams. Technological innovation can, however, also be a driver of exclusion and inefficiency. The marked inter-country differences in the diffusion of medical technology are a reflection, not of rational evaluation, but of the incentives to providers to adopt these technologies, and the capacity to control that adoption[2].

There are two reasons why the environment in which this is taking place is changing.

- Public contestation of the management of technology has continued to increase for reasons of trust, price, exclusion or unmet need.
- Regulation increasingly depends on supranational institutions. The European Union's regulatory system, for example, plays an increasing role in the harmonization of the technical requirements for registering new medicines or of product licencing, offering possibilities, among others, for more effective support to legal provisions encouraging generic substitution for pharmaceuticals in the private sector[8]. Such mechanisms offer opportunities to increase safety and access, and thus create an environment in which national primary care reforms are encouraged.

This comes at a time when the supply of professionals willing and able to engage in primary care is under stress. In Europe, for example, the population of general practitioners is ageing rapidly, and new recruits are more likely than before to opt for part-time or low-intensity careers[1]. There is pressure to give a more pivotal role to

Box 6.1 Norway's national strategy to reduce social inequalities in health[6]

Norway's strategy to reduce health inequalities illustrates that there is no single solution to this complex problem. Norway has identified a large number of determinants that influence the health of individuals: income, social support, education, employment, early childhood development, healthy environments and access to health services. These complex and interrelated determinants of health are not equally distributed in society, and it is, therefore, not surprising that this leads to inequities in health as well.

The Norwegian strategy attempts to address the root causes of poor health and health inequity by influencing the underlying determinants of health, and making the distribution of these determinants more equitable from the outset. The Norwegian strategy focuses on:

- reducing social inequities;
- reducing inequities in health behaviours and access to health services;
- targeted initiatives to improve social inclusion; and
- cross-sectoral tools to promote a whole-of-government approach to health.

This brings together a number of interventions that are effective in tackling inequities, and that can be applied both within health systems, as well as through cooperation with other sectors. For instance, health systems are able to establish programmes for early childhood development as well as policies that reduce financial, geographical and social barriers to health services for those who need care the most. Working with other sectors, such as labour and finance, can create job opportunities and taxation systems that encourage more equitable distribution and redistribution of wealth, which can have a large impact on population health. In addition to universal approaches, social inclusion interventions targeted at providing better living conditions for the most disadvantaged are also critical in reducing the gaps between the most well-off and the least well-off members of society.

family physicians in primary care[9]. In the long run, however, a more pluralistic approach will be required with teams that include a variety of professionals with the instruments to provide coordination and continuity of care. That will require a different, more varied and more flexible cadre of health workers. The sustainability of primary-care reforms in the category of high-spending countries is questionable without: (i) a change in paradigm of the training of health personnel; and (ii) the necessary career, social and financial incentives to move health professionals to what in the past have been less prestigious and rewarding career options.

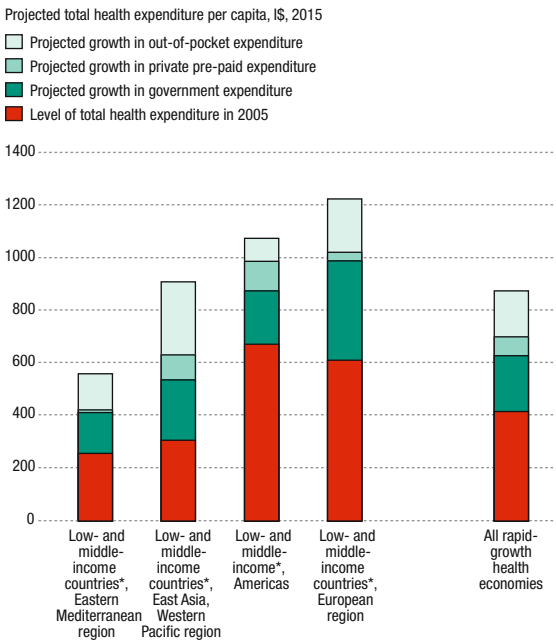
Spurred by the growing awareness of global health threats and of the stratification of health outcomes along social fault lines, there is a major renaissance in public health. The connections between health and other sectors are better understood and are bringing health to the attention of all sectors. Research and information systems, demand for public health training and new discourses on public health are occupying the centre stage of public concerns. This situation needs to be translated into multi-pronged cross-sector strategies to address the social determinants of health and their influence on priority health challenges (Box 6.1).

Over the last decades, most countries in this category are leading reforms through a steer-and-negotiate rather than a command-and-control approach. This reflects the growing public visibility of the health-policy agenda and the need to find a balance between the different and often irreconcilable demands of diverse constituencies. As a result, reform efforts are usually multi-levelled, with multiple actors. They progress incrementally: a protracted messy process of muddling through and hard bargaining. In England and Wales, for example, a major primary-care reform included an extensive public consultation through questionnaires addressed to more than 42 000 people, while over 1 000 individuals were invited to voice their interests and concerns in public hearings. This involvement facilitated consensus on a number of contentious parts of the reform, including shifts of resources to primary care and to underserved areas, while responsibilities were redistributed to improve cooperation and coordination[10]. Time and effort for systematic but principled negotiation is the price to pay for obtaining the social consensus that can overcome entrenched resistance to reform.

Rapid-growth health economies

In rapid-growth health economies, the challenge of engaging PHC reforms presents itself quite differently. The growing demand that comes with increased purchasing power is fuelling an expansion of services at unprecedented speed. Assuming current growth rates continue through to 2015, per capita health expenditure will grow by 60% in the fast-growing health economies of the Americas compared to 2005 levels. In the same time period, that expenditure will double in Europe and the Middle-East and triple in East Asia (Figure 6.2).

Figure 6.2 Projected per capita health expenditure in 2015, rapid-growth health economies (weighted averages)[a]



* Without fragile states.

[a] Assuming the yearly growth rates for government-, private pre-paid-, and out-of-pocket expenditure estimated from 1995–2005 data[5] persist to 2015.

While the rate of growth in expenditure represents an opportunity to engage in PHC reforms, it also fuels patterns of health-sector development that run counter to the vision and values

of PHC. Beginnings count: policy choices that are made for political or technical expediency, such as to refrain from regulating commercial health care, may make it more difficult to redirect health systems towards PHC values at a later stage, as powerful vested interests emerge and patterns of supply-induced demand become entrenched[11]. Biases towards highly sophisticated and specialized infrastructures that cater to the expectations of a wealthy minority are being further fuelled by a new growth market in medical tourism whereby patients from high-expenditure health economies with high-fixed costs are out-sourced to these comparatively low-cost environments. This drains the supply of professionals for primary care, encouraging unprecedented rates of specialization within the workforce[12]. In contrast with these developments, ministries of health in many of these countries are still organized around specific disease control efforts, and are ill-equipped to use the leverage of expanding resources to regulate health-care delivery. The result is all too often a two-tiered system, with highly sophisticated and specialized health infrastructure that caters to expectations of a wealthy minority, in the presence of huge gaps in service availability for a large part of the population

Reforms that emphasize universal access to people-centred primary care can help to correct such distortions. These reforms can take advantage of technological innovations that facilitate rapid, simple, reliable and low-cost access to services that were previously inaccessible because they were too expensive or required complex supportive infrastructure. Such innovations include rapid diagnostic tests for HIV and gastric ulcers, better drugs that facilitate the shift from institution-based to primary care-based mental health[13], and advances in surgery that either eliminate or dramatically reduce the need for hospitalization. Combined with the multiplication of evidence-based guidelines, such innovations have considerably enlarged the problem solving capacity of primary-care teams, broadening the role of non-physician clinicians[14] and the potential of self-care. Rapid expansion of people-centred care is thus possible in a context where the technological gap between close-to-client ambulatory care and tertiary institutions is less striking than it was 30 years ago. Chile, for example, has doubled the uptake of primary-care services in a period of five years, along with a massive investment in personnel and equipment ranging from emergency dental care and laboratories to home-based management of chronic pain. The impact of this transformation can be amplified by targeting and empowering the large numbers of poor and excluded in these countries and by reforming public policies accordingly.

In the rapid-growth health economies of the Americas and the European region less that one third of the expected growth on current trends is through increased out-of-pocket expenditure on health. Two thirds are through increased government expenditure, in combination, in the Americas, with expanded private pre-paid expenditure (Figure 6.2). The latter also plays a growing role in the Far East, where, as in the Middle East, around 40% of the growth, on current trends, will be in out-of-pocket expenditure. Leverage of PHC reforms will depend in part on the possibility to regulate and influence private pre-paid expenditure, and, particularly in Asia, to curb the reliance on out-of-pocket expenditure.

In most of these countries, the level of expenditure compared to GDP or to total government expenditure remains low, offering financial room to further accelerate PHC reforms and underpin them through parallel, and equally important, moves towards universal coverage and reduced reliance on out-of-pocket payments. In many of these countries, public resources are allocated on a capitation basis as are, at least, part of pooled private pre-payment funds. This provides opportunities to include criteria, such as relative deprivation or unmet health needs in the capitation formulas. This effectively transforms resource allocation into an instrument for promoting health equity and for introducing incentives favouring conversion towards primary care and healthier public policies.

Some of the largest countries in the world – Brazil, for example – are now seizing these kinds of opportunities on a massive scale, expanding their primary-care networks while diminishing their reliance on out-of-pocket payments[15]. Such reforms, however, rarely come about without pressure from the user's side. Chile's health policy

has defined a detailed benefit package, well publicized among the population as an enforceable right. People are being informed about the kind of services, including access to specialized care, which they can claim from their primary-care teams. In combination with sustained investment, such unambiguous entitlements create a powerful dynamic for the development of primary care. Managed well, they have the potential to accelerate convergence while avoiding at least part of the distortions and inefficiencies that have plagued high-income countries in earlier years.

Low-expenditure, low-growth health economies

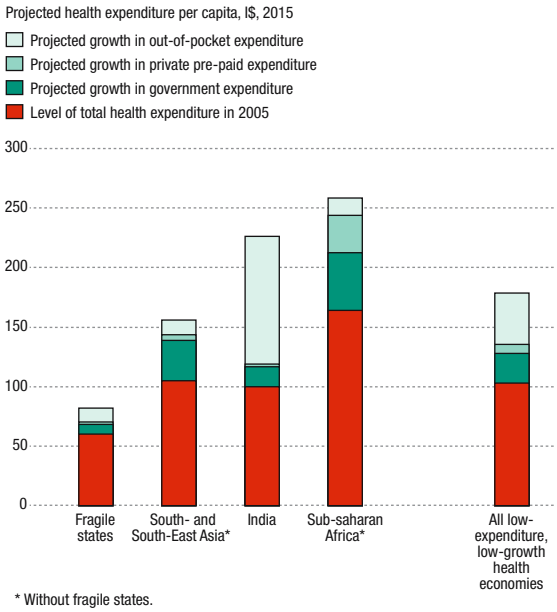
With 2.6 billion people and less than 5% of the world's health expenditure, countries in this group suffer from an absolute under-funding of their health sector, along with a disproportionally high disease burden. The persistence of high levels of maternal mortality in these countries – they claim close to 90% of all maternal deaths – is perhaps the clearest indication of the consequences of the under-funding of health on the performance of their health systems.

Worryingly, growth in health expenditure in these countries is low and highly vulnerable to their political and economic contexts. In fragile states, particularly in those located in Africa, health expenditure is not only low but barely growing at all, and 28% of this little amount of growth in recent years is accounted for by external aid. Health expenditure in the other countries of this group is growing at a stronger average rate of 6% to 7% per year. On current trends, by 2015, per capita health expenditure will have more than doubled in India compared to 2005, and increased by half elsewhere, except in fragile states (Figure 6.3). In many countries, this represents significant leverage to engage PHC reforms, particularly where the growth is through increased government expenditure or, as in Southern Africa, through other forms of prepayment. In India, however, more than 80% of the growth will, on current trends, be in out-of pocket expenditure, offering much less leverage.

Countries in these regions accumulate a set of problems that in all their diversity share many characteristics. Whole population groups are excluded from access to quality care: because no services are available; because they are too expensive, or under-funded, under-staffed and under-equipped; or because they are fragmented and limited to a few priority programmes. Efforts to establish sound public policies that promote health and deal with determinants of ill-health are limited at best. Unregulated commercialization of both private- and public-health care is quickly becoming the norm for urban and, increasingly, for rural populations – a much bigger and more underestimated challenge to PHC's values than the verticalism that so worries the international health community.

In most of these countries, the state has had, in the past, the ambition to run the health sector on an authoritarian basis. In today's pluralistic context, with a multitude of different providers, formal and informal, public and private, only few have succeeded in switching to more appropriate steer-and-negotiate approaches. Instead, as public resources stagnated and bureaucratic mechanisms failed, laissez-faire has become the default approach to management of the health sector.

Figure 6.3 Projected per capita health expenditure in 2015, low-expenditure, low-growth health economies (weighted averages)[a]



* Without fragile states.

[a] Assuming the yearly growth rates for government-, private pre-paid-, and out-of-pocket expenditure estimated from 1995–2005 data[5] persist to 2015.

This has resulted in few or feeble attempts to regulate commercial health-care provision – not only by the private, but also within the public sector, which has, in many instances, adopted the commercial practices of unregulated private care. In such settings, government capacity often limits the extent to which new resources can be leveraged for improved performance. Health authorities are, thus, left with an unfunded mandate for steering the health sector.

Therefore, growing the resource base is a priority: to refinance resource-starved health systems; to provide them with new life through PHC reforms; and to re-invest in public leadership. Prepayment systems must be nurtured now, discouraging direct levies on the sick and encouraging pooling of resources. This will make it possible to allocate limited resources more intelligently and explicitly than when health services are paid for out-of-pocket. While there is no single prescription for the type of pooling mechanism, there are greater efficiencies in larger pools: gradual merging or federation of pre-payment schemes can accelerate the build-up of regulatory capacity and accountability mechanisms[16].

In a significant number of these low-expenditure, low-growth health economies, particularly in sub-Saharan Africa and fragile states, the steep increase in external funds directed towards health through bilateral channels or through the new generation of global financing instruments has boosted the vitality of the health sector. These external funds need to be progressively re-channelled in ways that help build institutional capacity towards a longer-term goal of self-sustaining, universal coverage. In the past, the bulk of donor assistance has targeted short-term projects and programmes resulting in unnecessary delays, or even detracting from the emergence of the financing institutions required to manage universal coverage schemes. The renewed interest among donors in supporting national planning processes as part of the harmonization and alignment agenda, and the consensus that calls for universal access, represent important opportunities for scaling up investments in the institutional apparatus necessary for universal coverage. While reduced catastrophic expenditure on health care and universal access are sufficiently strong rationales for such change in donor behaviour, the build-up of sustainable national financing capacities also offers an eventual exit strategy from donor dependence.

Governments can do more to support the health sector in these settings. Low-expenditure, low-growth health economies allocate only a small fraction of their government revenue to health. Even in sub-Saharan African countries, which have made progress and allocated an average of 8.8% of their government expenditure to health in 2005, the Abuja Declaration target of 15% is still a long way off[5]. Reaching that target would increase total health expenditure in the region by 34%. Experience of the last decade shows that it is possible to increase government revenues allocated to health rapidly. For example, following rising pressure from a broad range of civil society and political movements, India's general government expenditure on health – with a specific focus on primary health care – is expected to triple within the next five years[17]. In a different context, the Ministry of Health in Burundi quadrupled its budget between 2005 and 2007 by successfully applying for funds that became available through debt reduction under the Enhanced Heavily Indebted Poor Countries (HIPC) initiative. On average, in the 23 countries at completion point for the HIPC and Multilateral Debt Relief Initiative (MDRI), the annual savings from HIPC debt relief during the 10 years following qualification are equivalent to 70% of public spending on health at 2005 levels[18]. While only part of that money is to be directed to health, even that can make a considerable difference to the financial clout of public-health authorities.

Opportunities arise not only from increased resources. The preponderance of pilot projects is gradually being replaced by more systematic efforts to achieve universal access, albeit often for a single intervention or disease programme. These high visibility programmes, developed in relation to the MDGs, have revitalized a number of concepts that are key to people-centred care. Among them are the imperative of universal access to high quality and safe care without financial penalty, and the importance of continuity of care, and the need to understand the social, cultural and economic context in which all

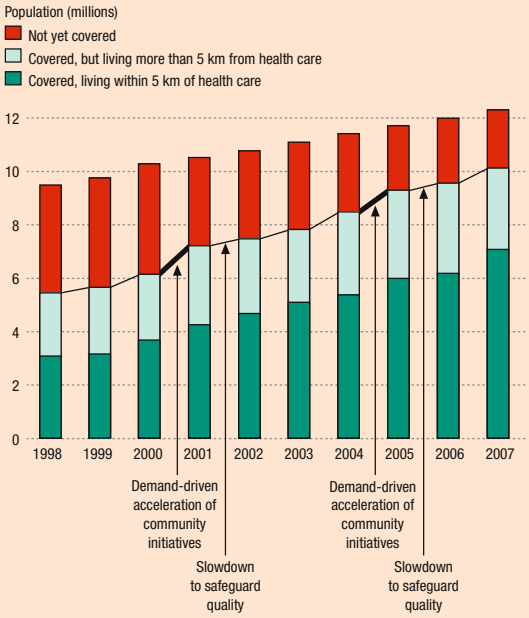
Box 6.2 The virtuous cycle of supply of and demand for primary care

In Mali, the primary care network is made up of community-owned, community-operated primary-care centres, backed up by government-run district teams and referral units. There is a coverage plan, negotiated with the communities, which, if they so wish, can take the initiative to create a primary-care centre according to a set of criteria. The commitment is important, since the health centre will be owned and run by the community: for example, the staff of the health centre, a three to four person team led by a nurse or a family doctor, has to be employed (and financed) by the local community health association. The community can make an agreement with the Ministry of Health to obtain technical and financial support from the district-health teams, for the launch of the health centre and the supervision and back up of its subsequent operation.

The model has proved quite popular, despite the huge effort communities have had to put into the mobilization and organization of these facilities: by 2007, 826 such centres were in operation (up from 360 10 years before), set up at an average cost of US$ 17 000. The system has proved resilient and has significantly increased the production of health care: the number of curative care episodes managed by the health centres has been multiplied by 2.1. The number of women followed up in antenatal care has been multiplied by 2.7 and births attended by a health professional by 2.5, with coverage levels as measured through Demographic Health Surveys in 2006 standing at 70% and 49%, respectively; DTP3 vaccination coverage in 2006 was 68%.

People obviously consider the investment worthwhile. Twice during the last 10 years, between 2000 and 2001 and 2004 and 2005, demand and local initiative for the creation of new centres was rising so fast that Mali's health authorities had to take measures to slow down the expansion of the network in order to be able to guarantee quality standards (Figure 6.4). This suggests that the virtuous cycle of increased demand and improved supply is functioning. Health authorities are expanding the range of services offered and improving the quality – by encouraging the recruitment of doctors in the rural primary-care centres – while continuing their support to the extension of the network.

Figure 6.4 The progressive extension of coverage by community-owned, community–operated health centres in Mali, 1998–2007



Source: Système national d'information sanitaire (SNIS), Cellule de Planification et de Statistiques Ministère de la Santé Mali [National health information system (SNIS), Planning and Statistics Unit, Ministry of Health, Mali].

men, women and families of a given community live. Integration is becoming a reality through approaches, such as the Integrated Management of Adolescent and Adult Illness (IMAI) and the community-based interventions emerging from the Onchocerciasis Control Programme (OCP)[19]. Global initiatives are loosening their grip on disease-control mandates and are beginning to appreciate the importance of strengthening the system more generally, such as through GAVI Alliance's Health System Strengthening window, paving the way for better alignment of previously fragmented initiatives. Driven largely by demand, information technologies to support primary care, such as electronic medical records, are spreading much faster than anticipated. Efforts to scale up HIV treatment have helped to expose the shortfalls in key systems inputs, such as the supply chain management of diagnostics and drugs, and build bridges to other sectors, such as agriculture, given the imperative of food security. Emerging awareness of the magnitude of the workforce crisis is leading to ambitious policies and programmes, including task shifting, distance learning and the innovative deployment of financial and non-financial incentives.

In this context, the challenge is no longer to do more with less, but to harness the growth in the

health sector to do more with more. The unmet need in these countries is vast and making services available is still a major issue. It requires a progressive roll-out of health districts – whether through government services or by contracting NGOs, or a combination of both. Yet the complexities of contemporary health systems, particularly, but not only in urban areas, call for flexible and innovative interpretations of these organizational strategies. In many of Africa's capitals, for example, public facilities of primary, and even secondary, level have almost or completely disappeared, and have been replaced by unregulated commercial providers[20]. Creative solutions will have to build on alliances with local authorities, civil society and consumer organizations to use growing funds – pooled private pre-payment, social security contributions, funds from municipal authorities and tax-sourced funding – to create a primary-care offer that acts as a public safety net, as an alternative to unregulated commercial care, and as a signal of what trustworthy, people-centred health care can look like.

What eventually matters is the experience of patients accessing services. Trust will grow if they are welcomed and not turned away; remembered and not forgotten; seen by someone who knows them well; respected in terms of their privacy and dignity; responded to with appropriate care; informed about tests; and provided with drugs and not charged a fee at the point of service.

Growing trust can induce a virtuous cycle of increased demand and improved supply (Box 6.2). The gain in credibility that comes from instating such a virtuous cycle is key to gaining social and political consensus on investment in healthier public policies across sectors. Effective food security, education and rural-urban policies are critical for health and health equity: the health sector's influence on these policies depends to a large extent on its performance in providing quality primary care.

Mobilizing the drivers of reform

Across all of the diverse national contexts in which PHC reforms must find their specific expression, globalization plays a major role. It is altering the balance between international organizations, national governments, non-state actors, local and regional authorities and individual citizens.

The global health landscape is not immune to these wider changes. Over the last 30 years, the traditional nation state and multilateral architecture have been transformed. Civil society organizations have mushroomed, along with the emergence of public-private partnerships and global advocacy communities identified with specific health problems. Governmental agencies work with research consortia and consulting firms as well as with non-state transnational institutions, foundations and NGOs that operate on a global scale. National diasporas have appeared that command substantial resources and influence with remittances – about US$ 150 billion in 2005 – that dwarf overseas development aid. Illicit global networks make a business out of counterfeit drugs or toxic waste disposal, and now have the resources that allow them to capture and subvert the capacity of public agencies. Power is gravitating from national governments to international organizations and, at the same time, to sub-national entities, including a range of local and regional governments and non-governmental institutions[21].

This new and often chaotic complexity is challenging, particularly to health authorities that hesitate between ineffective and often counterproductive command and control and deleterious laissez-faire approaches to governance. However, it also offers new, common opportunities for investing in the capacity to lead and mediate the politics of reform, by mobilizing knowledge, the workforce and people.

Mobilizing the production of knowledge

PHC reforms can be spurred and kept on track by institutionalizing PHC policy reviews that mobilize organizational imagination, intelligence and ingenuity. The know-how to conduct policy reviews exists[22], but requires more explicit articulations. They need to refocus on monitoring such progress with each of the four interlocking sets of PHC reforms; on identifying, as they unfold, the technical and political obstacles to their advancement; and on providing the elements for course corrections, where necessary.