Summary Statement

- **What is known about the topic?**
- Strengthening primary health care leads to improved population health outcomes at lower cost, paving the way towards universal health coverage.
- **What does this paper add?**
- Through a critical comparative dialogue analysing the primary health care policy of 6 Asia-Pacific countries, key areas for regional development are identified and core recommendations for future policy outlined.

Summary text for the Table of Contents

Strengthening primary health care (PHC) leads to improved population health outcomes at lower cost, paving the way towards universal health coverage. Through a critical comparative dialogue analysing the PHC policy of six Asia-Pacific countries, we have identified key areas for regional development, and outline core recommendations for future policy. Successful PHC policy in Asia-Pacific region requires sustainable equitable public-private partnerships, structured approaches to information-sharing, improved multi-disciplinary team focused on both public and professional health literacy, systems that can evaluate and improve quality of care by PHC providers, and high-yield, high-quality community-based training programs to generate the workforce required to sustain the system.

Abstract

Primary health care is essential for equitable, cost-effective and sustainable health care. It is the cornerstone to achieving universal health coverage against a background of rising health expenditure and aging populations. Implementing strong primary health care requires grassroots understanding of health system performance. Comparing successes and barriers between countries may assist in identifying mutual challenges and possible solutions. This paper compares and analyses primary health care policy in Australia, Malaysia, Mongolia, Myanmar, Thailand and Vietnam. Data were collected at the World Organization of Family Doctors Asia-Pacific regional conference in November 2017 using a predetermined framework. The six countries varied in maturity of their primary health care systems, including the extent to which family doctors contribute to care delivery. Challenges included an insufficient trained and competent workforce, particularly in rural and remote communities, and deficits in coordination within primary health care, as well as between primary and secondary care. Asia-Pacific regional policy needs to focus on better collaboration between public and private sectors; take a structured approach to information-sharing through bridging gaps in technology, health literacy and interprofessional working; build systems that can evaluate and improve quality of care; and promote community-based high-quality training programs.

Additional keywords: Family doctor; General practice; Primary Health Care; Universal Health Coverage; International collaboration; Global health; Social determinants of health.

Introduction

The healthcare systems of the Asia-Pacific region (China, South-East Asia, Australia, New Zealand and Pacific Islands) are straining against rising health costs and diminished returns on healthcare investment, particularly in response to ageing populations. Evidence indicates that formally structured primary health care (PHC) and a trained primary care workforce leads to improved population health at lower overall cost (Starfield 1994; Hansen *et al*. 2015). Strengthening PHC is therefore a World Health Organization (WHO) priority in achieving universal health coverage (UHC) (Pettigrew *et al.* 2015; Hone *et al.* 2018; Weel and Kidd 2018; WHO 2019), part of the United Nations' Sustainable Development Goals (United Nations 2015), and regional and global sustainable healthcare (WHO 2008).

In order to implement a strong PHC policy, it is necessary to have an understanding of both the existing health system from a grassroots level, and the application of general principles adapted to the prevailing local conditions. While PHC systems in Europe, North America and Australasia (Australia and New Zealand) have been well-documented and compared (I LIVE PC 2012; Kringos *et al* 2013; Hutchison and Glazier 2013; Pavlič *et al.* 2018), this is less the case in many low- and middle-income countries (LMIC). Over the past few years the World Organization of Family Doctors (WONCA) Working Party on Research has undertaken work to examine and document how PHC values may be addressed and implemented within the constraints of diverse health care systems globally (WONCA 2019). Earlier studies have documented findings from the Asia-Pacific (Weel *et al.* 2016), South Asia (van Weel *et al.* 2016), Africa (Mash *et al*. 2018), East Mediterranean (van Weel *et al.* 2017) and Central and South American (Ramirez Aranda *et al.* 2017; Acosta Ramirez *et al.* 2016) regions (Van Weel and Howe, 2018), identifying common challenges and priorities to strengthen PHC and secure UHC – despite differences in culture, demography and health systems.

This is the second paper to document and critically appraise the PHC systems in the Asia-Pacific region, with the objective of identifying common strategies for strengthening PHC and prioritising recommendations for international collaboration across the region. The first paper discussed PHC in China (Shanghai, Hong Kong), Japan, South Korea, Singapore, and Taiwan (Weel *et al*. 2016).

Country comparisons

The comparisons of six PHC systems (Australia, Malaysia, Mongolia, Myanmar, Thailand and Vietnam) were presented at a panel discussion at the 2017 WONCA Asia-Pacific regional conference held in Pattaya, Thailand. Expert academic family doctors presented their country details, using the predetermined WONCA framework of 11 templated PowerPoint slides, which focused on country demographics; PHC structure; role; types of community disciplines; role of teams in service provision; relationship to other community services; benefits and barriers in addressing the impact of community-based PHC teams on patient care and population health; ways community-based PHC teams supported or impeded proactive responses to community

health needs; and lessons for other countries. All panel presenters, moderators and delegates contributed to the discussion directed at strategies to strengthen PHC, and the focus was given to possible contributions that could be made through regional and international collaboration.

Following the workshop, a framework analysis was conducted of the data provided from the six PowerPoint presentations plus the resultant discussion, further informed through comparative population-level health markers for each country.

Australia

The foundation of PHC delivery in Australia is a strong and well-established system of general practice. Most PHC is delivered to Australians by individual general practitioners (GPs), with PHC teams uncommon, except in Aboriginal health. There has been investment in the quality of general practice and PHC through professional training, research and development for over 30 years, however without a system of PHC teams the "*health care service delivery system is complex, fragmented and often uncoordinated*" (Department of Health and Ageing 2009).

Malaysia

A combination of public and private funded health care has served the Malaysian population since the 1950s. In response to the changing morbidity patterns from communicable to non-communicable diseases (NCDs), integration of care in the public sector has been the priority of primary care services. The Ministry of Health has expanded the primary care infrastructure, investing in training family doctors and moving chronic disease management and health promotion from secondary to primary care settings (Lim *et al*. 2017), including chronic disease management and HIV clinics. Rising health care costs has shifted the burden of care from private to the heavily subsidised public sector, where resources are already over-stretched (Ministry of Health, Malaysia 2016). Overall, an integrated public-private system with increased funding for primary care is urgently needed.

Mongolia

Mongolia has Family Health Centres (FHCs) where health care workers are organised into "partnerships". FHCs provide services based on contractual arrangements between the district/province governor and the health centres. FHCs are responsible for implementing government-approved public health programs; conducting population screening for and monitoring patients with NCDs; and referring patients to secondary or tertiary centres as appropriate (Center for Health Development 2016). Because FHCs are solely funded by capitated payment from the state budget, they have no independence to augment services through the private sector nor develop true community-based PHC. In practice there are a few doctors and nurses trained in family medicine, and an inadequate referral system with poor relationships between primary and secondary care.

Myanmar

PHC in Myanmar is provided by a combination of medical professionals funded by the Ministry of Health and Sports, the Ministry of Labour and the Ministry of Defence; private GPs, national and international non-governmental organisations, and third sector providers. Medical officers, dental officers and private GPs are the main PHC providers in urban and semi-urban areas, whereas health assistants, female health visitors, midwives and health supervisors are the key providers in rural areas (Latt *et al*. 2016). Although a national health insurance policy was started in 2015, PHC disciplines, including ambulatory care, are not covered, with resulting high out-of-pocket costs to patients. The impact of PHC activities on patient care is unclear. Barriers to achieve comprehensive PHC at individual and community levels include low funding allocation of the government health care budget, low population health literacy, disparities in access to, and utilisation of, health services by the poor, and limited health information systems.

Thailand

In recent decades UHC reform has been a major achievement for the Thai health care system. A strong foundation of PHC has demonstrated a reduction in geographic barriers to access, however effective PHC delivery remains a challenge despite establishing family doctor training and a financial management overhaul (Prakongsai *et al*. 2017). Recent family doctor training is focused on collaboration with a multi-disciplinary team, reshaping the PHC model. Policy supporting PHC has focused on the public sector, with efforts to improve public primary care infrastructure, but human resources remains limited. PHC has experienced a chronic staff shortage and increased demand for services, affecting health promotion and disease prevention programs (Kitreerawutiwong *et al*. 2017). Community ownership, administered through district health boards, to promote multi-sectorial collaboration and social entrepreneurship is essential to improve PHC delivery in Thailand.

Vietnam

In the last decade, the Vietnamese Ministry for Health has supported open health care access through PHC (Tuan 2016). PHC system has played an important role in achieving the goal of UHC, which can be improved further with the upgrading of information and communication technology (ICT) systems, a family medicine training program, and an established policy for the PHC sector. Key priorities for PHC services over the next decade will be reducing medical costs and overcrowding in secondary and tertiary care. PHC teams at a grassroots level should be competent to provide integrated, comprehensive and patient-centred care at “Commune Health Centres” that prioritise the doctor-patient relationship. However, the lack of a national accreditation system and licensing standards needs to be addressed urgently. Close collaborative and multi-disciplinary team working in PHC is required.

Comparative statistics

The relative populations and a number of population-level health markers for the six countries are shown in Table 1. The life expectancy clearly differentiates the three lower middle-income countries, Mongolia, Myanmar and Vietnam, from the two upper middle-income countries Thailand and Malaysia, and then Australia as a high-income country. A similar pattern can be seen in the maternal, neonatal and infant mortality rates and the probability of dying from a non-communicable disease between the age of 30 to 70 years. Thailand stands out as doing well despite being the country with the lowest number of doctors per 10,000 inhabitants and a relatively older population, and this may be attributed to its UHC achieved through strengthening PHC.

Discussion

These six countries vary in the maturity of their PHC systems, their journey towards UHC, and the extent to which family doctors deliver PHC. However common issues to overcome, derived directly from the panel discussions, are shortages in the PHC workforce, particularly in rural and remote communities, and lack of coordination within PHC, and between primary and secondary care.

Collaboration between public and private sectors

The roles of public and private sectors in PHC, and ways in which they collaborate with each other differ between countries. Malaysia has a dual system where locations, PHC team members, morbidity patterns and financing mechanisms differ between public and private sectors. In Australia, general practices are largely private businesses, but consultations are subsidised by the government. In Myanmar, many PHC providers in both public and private sectors work in a complementary manner, while there are moves in Mongolia to develop a public-private partnership through legislation.

An important issue in public-private collaboration is the unequal health care burden between the two sectors. Given the difference in financing between these two sectors and the increasingly expensive cost of long-term chronic disease management, patient preference is likely to sway towards and hence over-burden the public sector. This problem is more pronounced if both sectors provide similar primary care services. Therefore, focus should be on developing a more sustainable health financing system, which may include unified health financing for both public and private sectors, or creating complementary roles and responsibilities between the two. The private sector in health care service provision may have significant role in achieving UHC. Private sectors have the potential to accelerate innovation in the health care system; however, regulation by the government and other stakeholders is needed with regards to quality, access and costs, in keeping with the public sector.

Gatekeeper role

In Australia, general practice functions as a gatekeeper to secondary care, with specialist access through GP referral only. In Mongolia, nearly every FHC looks after a defined and enrolled population, whereas in Malaysia, only primary care in the public sector has a gatekeeper function.

These three versions of a gatekeeping role illustrate how each country's health care system is dependent on quality of care in general practice, continuity of care, budget allocation between primary and secondary care, and patients' out-of-pocket expenditure on health. Generalisable recommendations are not appropriate, as each country needs to make its own road-map directed by its individual economic development and political environment. It may be difficult to implement a gatekeeping function and enrolment system in countries facing rapid development or with large mobile populations such as refugees and migrants. Despite debate about the value of gatekeeping (Greenfield and Foley 2016), it is a powerful instrument to reduce inequalities and promote integrated care.

Information and communication technology

Availability of ICT in PHC varies between our case countries. However, even in those with advanced ICT systems, information-sharing between primary and secondary care is still inadequate to ensure effective referrals and continuity of care. This is not just a matter of technology, but also of common understanding between health care professionals and addressing health literacy gaps. These gaps exist between the providers of PHC and secondary care, and between patients and healthcare providers, with resultant communication breakdown and unsatisfactory patient health outcomes (MacLeod *et al*. 2017). Platforms for communication need to be developed collaboratively. This creates a line of standardised communication and opportunity for interprofessional learning. As insights into health literacy (Rudd 2013) and shared decision-making (Elwyn *et al*. 2017) evolve, we need a structured approach to information-sharing, upskilling the PHC workforce in interprofessional communication and multidisciplinary learning, whilst looking to educate patient groups to improve health literacy.

Social determinants of health

The Asia-Pacific region is richly diverse, not only through its geography, climate, history, culture, language and politics, but also in the distribution of social determinants of health (SDH) in its populations. The social and economic burden due to an aging population and prevalent NCDs is a challenge all countries will face sooner or later. Implementation of PHC in all Asia-Pacific countries must take SDH into consideration. Access to health care is more challenging for those with a large rural population, such as Myanmar and Vietnam (Table 1). The circumstances in which people grow, live, work, and age, create (avoidable) inequities in health, shaped by political, social and economic forces. Wars, conflicts and disasters also negatively contribute to SDH. It is ten years since the WHO's Commission on Social Determinants of Health final report (Commission of Social Determinants of Health 2008), and work is needed to verify how much these recommendations have been put into practice. PHC works beyond providing acute and chronic care in isolation, and achieving community engagement, continuity and empowerment to promote a healthier social environment requires a collaborative effort.

Universal health coverage

Better access to PHC is the most efficient and affordable way to achieve UHC, as illustrated by Thailand. Expansion of PHC services has been shown to lead to increased UHC and improved health outcomes (Hsieh *et al*. 2015). On the other hand, financial constraints has made it difficult for Myanmar to achieve UHC. On a global scale, at least half the world's population still lacks access to essential health services – over 800 million people spend more than 10% of their household budget on health care, and almost 100 million people are pushed into extreme poverty each year, due to out-of-pocket health expenditures (World Bank 2017). Even countries that have achieved UHC still experience the impact of aging, with the increased prevalence of NCDs and multi-morbidity, as illustrated in Table 1. As we have passed the 40th anniversary of the Alma Ata Declaration (WHO 1978), an important milestone in the development of PHC, it is important to rethink the roles of family doctors in PHC and UHC now. Promoting high-quality research that explores the cost-effectiveness of PHC, as well as building systems that appropriately evaluate and improve the quality of care given by PHC providers including family doctors ,should be added to the roles of PHC providers, and not neglected on the road towards UHC (Weel and Kidd 2018).

Lack of PHC workforce

The disparity in the PHC workforce adequacy between urban and rural communities is large, and constitutes a major issue in all the six countries. Many Australian rural GP positions are filled by overseas-trained graduates and locums. Most doctors employed by FHC in Mongolia are new graduates with little or no clinical experience. Dispatching inexperienced or in-training doctors to rural and/or remote communities with little supervision can create safety issues for both doctors and patients, undermining confidence and trust on both sides. Education, supervision and mentorship can play a major positive role, however lack of training capacity challenges to ability to fulfil the required number of healthcare professionals needed to sustain the workforce. Our earlier analysis has revealed that over-reliance of health policy on hospital settings as the main provider of care, as well as lack of professional training, are the major system barriers to strengthening PHC (van Weel and Kassai 2017). We need to promote community-based high yield, high-quality training programs in PHC, ensuring positive coverage at medical schools with students exposed to family medicine as a career choice. Family doctor training needs to be put in place ahead of systems changes, to ensure there is an adequate workforce to sustain the system.

Conclusion

Using the WONCA framework for a constructive comparative dialogue between health systems has revealed key recommendations for future directions in PHC policy implementation. Successful PHC policy in Asia-Pacific region requires:

- sustainable equitable public-private partnerships;
- structured approaches to information-sharing;
- improved multi-disciplinary team focused on both public and professional health literacy;
- systems that can evaluate and improve quality of care by PHC providers;
- high-yield, high-quality community-based training programs to generate the workforce

required to sustain the system.

These goals were articulated in the 1978 Alma Ata Declaration (WHO 1978) and further emphasised in the 2018 Astana Declaration (WHO 2018) which called for populations to be empowered to address their own health needs with high quality primary care and integrated public/private, and intersectoral services. In 2016, the WHO Western Pacific Office called for countries in the region to embed the health system attributes and corresponding action domains for the attainment of UHC and the Sustainable Development Goals into national health policy reform, followed up in 2018, with calls for a renewed focus on PHC values as part of a multisectoral commitment to UHC (WHO Regional Office for the Western Pacific, 2016 and 2018).

The future research agenda includes evaluating the value of gatekeeping and enrolment systems for individual health systems; seeking new methods to evaluation cost-effectiveness and quality of PHC internationally; and verifying the achievement of the WHO's SDH recommendations (Commission of Social Determinants of Health 2008). Achieving this will mark a key milestone in the quest for UHC sustained through strong, equitable and cost-effective PHC.

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Table 1 Country population health marker comparisons

Country	Population in millions*	% population urban 2018[a]	Doctors per 10,000 inhabitants[b]	Median age population (in yrs) 2020[c]	Estimate population >65 yr in 2020[b]	Average annual population change 2015-2020[b]	Maternal mortality ratio (/100,000 live births) 2016[d]	Neonatal mortality rate (/1000 live births) 2015[e]	Under-5 mortality (/1000 live births) 2015[e]	Life expectancy at birth (in yrs) 2015[e]	Probability of dying from CVD, cancer, diabetes, or CRD age 30-70 yrs (%) 2012[e]
Australia	24.5	86	35	37.9	16%	1.27%	6	3.8	3.8	82.8	9.4
Malaysia	31.7	76	15.8	30.3	7%	1.79%	30	7.0	19.6	75.0	19.6
Mongolia	3.1	68	32.4	28.2	4%	0.31%	47	22.4	22.4	68.8	32.0
Myanmar	51.4	31	5.7	29.0	6%	0.65%	246	24.3	50.0	66.6	24.3
Thailand	68.8	50	4.7	40.1	13%	0.31%	38	16.2	12.3	74.9	16.2
Vietnam	91.7	36	8.8	32.5	8%	0.98%	45	21.7	14.9	76.0	17.4

[a] United Nations Population Division. World Urbanization Prospects 2018

[b] WHO Western Pacific Region 2014

[c] United Nations World Population Prospects 2019

[d] WHO Global Health Observatory country views

[e] WHO 2016: Monitoring health for the SDGs Annex B: tables of health statistics by country, WHO region and globally

Yr = year; CVD = cardiovascular disease: CRD = chronic respiratory disease