Leap toward health for all: a primary care series

Paper 1: Primary care principles

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Introduction

Primary healthcare (PHC) has long been recognized as the foundational pillar of an effective health system. Since the 1978 Declaration of Alma-Ata positioned PHC as the key strategy to achieve Health for All, global health leaders have emphasized its central role in improving population health and equity.[1] PHC represents a shift from viewing health solely in terms of hospitals and specialists to a broader, community-centric approach grounded in human rights, social justice and intersectoral action.[2]

Over the past four decades, countries have struggled at times to implement this vision. They have debated how to balance disease-specific programs with comprehensive community health. Challenges have also arisen around how to finance and staff primary care, as well as how to institutionalize equity and community participation.[1]

Nonetheless, evidence consistently shows that strong PHC yields better health outcomes, improved equity and more efficient use of resources. For instance, health systems oriented around robust primary care have lower infant mortality rates, higher life expectancy and narrower disparities, all while keeping costs under control.[3]

Barbara Starfield's seminal work demonstrated that regions with a higher density of primary care physicians have healthier populations and that the core attributes of primary care are linked to superior health indicators. High-performing health systems in countries like Australia, the Netherlands and the United Kingdom (UK), which top international rankings, are notable for their strong primary care infrastructure and universal coverage. This stands in stark contrast to systems that under-invest in primary care.[4]

The imperative for robust PHC has only grown in recent years. In 2019, all UN member states declared their intent to prioritize PHC in pursuit of health for all. The COVID-19 pandemic further underscored the importance of resilient primary care. Countries with strong PHC networks were better able to deliver testing, tracing, vaccination and essential services during the crisis, while others struggled to maintain continuity of care.

The COVID-19 pandemic catalyzed innovations such as telemedicine and community outreach that showcased how adaptable and indispensable primary care can be in emergencies. For example, telehealth usage surged dramatically – in the United States (US), the proportion of physicians using telemedicine jumped from about 15% in 2019 to 86% by 2021 as regulations eased and demand rose.[5] Around the world, primary care providers rapidly adopted remote consultations, home-based care models and closer integration with public health efforts in response to the pandemic. These lessons have prompted renewed investments in PHC to "build back better" with more resilient, accessible frontline services.[6]

This paper is part of a three-paper series and provides an overview of PHC, what it is, its core principles, key examples, benchmark countries and its successes and gaps. The aim is to offer a thought leadership perspective on why strengthening PHC is not only a moral imperative but also a sound strategy for sustainable health systems development.

Defining PHC

PHC is defined by the World Health Organization (WHO) as a "whole-of-society approach" to organizing and strengthening a country's health system, bringing comprehensive health services closer to communities.[6]

> "In practical terms, PHC is essential healthcare that is 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]

WHO describes PHC as encompassing three interrelated components:

1. **Integrated health services** that meet most people's health needs throughout their life; from preventive and promotive care to treatment, rehabilitation and palliative care.
2. **Attention to the broader determinants of health** through multisectoral policies and actions; addressing factors like education, nutrition, water and sanitation, and socioeconomic conditions.
3. **Empowerment of individuals, families and communities** to take charge of their own health through education, engagement and social mobilization.

Under a PHC approach, healthcare is **people-centered** and delivered as close as possible to where people live and work. Services are designed to be **accessible** and appropriate to the community's needs, with prevention and health promotion given equal importance to curative care.

PHC is usually the **first point of contact** for people who need medical attention, typically provided through local clinics, general practitioners or community health workers. It provides continuity of care by coordinating referrals to higher levels of treatment whenever necessary.

By emphasizing universal access, equity and community participation, PHC aims to reduce disparities in health status. WHO notes that PHC is widely regarded as the most inclusive and cost-effective path to enhancing population health and achieving universal health coverage.[6] It builds fundamental system resilience, meaning health systems oriented around PHC are better prepared to withstand shocks like epidemics or natural disasters.

Indeed, PHC-oriented systems consistently produce better health outcomes, greater equity and improved efficiency in resource use. According to recent WHO estimates, scaling up evidence-based PHC interventions in low- and middle-income countries (LMICs) could save 60 million lives. Additionally, it could increase average life expectancy by 3.7 years by 2030. This is a testament to the tremendous impact of primary care on global health.

All primary care falls under the umbrella of PHC, but PHC extends far beyond clinical services. It represents a holistic framework for health system design. This broad, system-wide approach is what makes PHC such a powerful driver of improved health equity and outcomes.

PHC has evolved significantly over the past century, shaped by global health priorities and socio-political change.

The COVID-19 pandemic was the most significant disruption to health systems in a century and highlighted the central role of PHC

in both crisis response and continuity of care. Around the world, primary care providers had to adapt rapidly, revealing both strengths and long-standing deficiencies in PHC systems.

One of the most immediate shifts was the large-scale adoption of telemedicine. Virtual consultations allowed many countries to maintain essential services under lockdown conditions, with usage expanding almost overnight in the US, the UK and elsewhere. This demonstrated the capacity of PHC to integrate digital solutions at scale, but it also exposed inequities linked to the digital divide, underscoring that telemedicine should complement rather than replace in-person care.

The pandemic also emphasized the importance of integrating PHC with public health functions. In countries with robust PHC networks, primary care facilities and community health workers (CHWs) became critical to surveillance, contact tracing and vaccine delivery. Conversely, in contexts where PHC was fragmented, governments had to establish parallel systems to manage testing and vaccination. These contrasts have renewed attention to building stronger institutional links between PHC and public health, including reforms around data-sharing and real-time outbreak monitoring. Such integration is increasingly seen as central to preparedness for future health emergencies.

At the same time, the COVID-19 pandemic exposed vulnerabilities in PHC financing and workforce sustainability. Many practices dependent on fee-for-service payments suffered financial strain as patient visits declined, while frontline staff faced heavy stress, shortages of protective equipment and limited surge capacity. These pressures have intensified calls for resilient financing models and stronger support for the PHC workforce. At the global level, the WHO has reiterated the need to place PHC at the core of both universal health coverage and pandemic preparedness.

Evolution of PHC: key milestones

- **1930** — **Basic rural services:** maternal/child health, infectious disease
- **1978** — **Alma-Ata Declaration:** PHC cornerstone of Health for All
- **1990** — **Selective PHC:** donor-driven vertical programs
- **2000** — **Millennium Development Goals:** renewed focus on PHC & health systems
- **2008** — **World Health Report:** PHC for universal health cover
- **2018** — **Astana Declaration:** integrated, resilient PHC
- **2020** — **COVID-19:** PHC frontline, digital innovations

Year

Core principles of PHC

Over time, scholars have refined how we understand PHC. While the Alma-Ata Declaration (1978) established PHC as a philosophy for equitable and community-based health systems, later work by Barbara Starfield and colleagues provided a framework for assessing what makes primary care effective in practice.[3] Subsequent research and international policy frameworks expanded on the existing principles. Taken together, these eight attributes form the modern benchmark for high-performing PHC systems:

1	**Accessibility (first-contact care)**	Services should be readily available to individuals and communities at the point of first contact, without barriers of geography, cost, culture or language.
2	**Continuity of care**	Patients should have a sustained, trusted relationship with a healthcare provider or team, promoting follow-up, consistency and long-term management of health conditions.
3	**Comprehensiveness**	PHC should address the broad spectrum of a person's health needs; from prevention and health promotion to acute treatment, chronic disease management, rehabilitation and palliative care.
4	**Coordination of care**	Effective PHC integrates and coordinates services across different levels of the healthcare system, promoting seamless referrals to specialists and hospitals while keeping the patient at the center.
5	**Patient-centeredness**	Care should respect patient preferences, needs, values and cultural contexts, with individuals actively engaged in decision-making.
6	**Prevention and health promotion**	Beyond treatment, PHC should emphasize preventing disease, promoting healthy behaviors and addressing upstream determinants of health.
7	**Equity**	PHC must work to reduce disparities, promoting equal access and quality for all populations, regardless of socioeconomic status or background.
8	**Community orientation**	Services should reflect the specific health priorities and resources of the communities they serve, promoting responsiveness and local relevance.

Countries that excel in these areas demonstrate that health systems grounded in these attributes deliver better outcomes, higher equity and greater efficiency.

01

Leading practices in PHC: lessons from six high-performing countries

PHC is widely regarded as the cornerstone of an effective health system. PHC-oriented systems consistently achieve better health outcomes, greater equity and higher efficiency. This report examines six countries — the UK, the Netherlands, Australia, New Zealand, Denmark and Brazil — that are recognized for exemplary PHC.

We explore each country's Leading practices, recent developments, health outcomes and how they uphold core PHC principles, explaining why they rank among the world's best.

UK

The UK's National Health Service (NHS) provides universal coverage funded by general taxation, with primary care delivered mainly by general practitioners (GPs) who act as gatekeepers. Every resident can access NHS services without paying at the time of care, so that affordability and equity are promoted in line with PHC principles. Patients register with local GP practices, which provide comprehensive first-contact care and coordinate referrals to specialists. This helps maintain continuity and efficient use of resources.[7]

Key strengths UK primary care is characterized by strong initiatives to improve quality and integrate services. The Quality and Outcomes Framework (QOF), a nationwide pay-for-performance program, incentivizes better management of chronic conditions and has improved care processes. GPs increasingly work in group practices with multidisciplinary teams, adopting a "medical home" approach for chronic disease management. Recent reforms

emphasize integration through primary care networks (PCNs) and integrated care systems (ICS), linking GPs with hospitals and social services to improve coordination. Early pilots have reduced avoidable hospital use.[7]

Outcomes and successes The UK's PHC system has supported strong population health, with life expectancy reaching about 82.2 years in 2024 (US Census) and relatively low preventable mortality. In a 2021 comparison of 11 high-income countries, the UK ranked in the top five overall, performing especially well on care processes. Universal coverage removes cost barriers, and equity remains a core focus, with local commissioners targeting resources to reduce disparities.[7,8]

Netherlands

The Netherlands achieves universal health coverage through mandatory social health insurance, with care delivery anchored in strong primary care.[8,9] Nearly all residents are registered with a GP of their choice, who serves as the first point of contact for most health needs. GPs provide a broad range of services — from preventive care and chronic disease management to minor procedures. They act as gatekeepers for specialist and hospital care, so that continuity and coordination are maintained.[10]

Key strengths Dutch primary care is highly organized and accessible, with regional GP cooperatives (GP posts) providing after-hours care and reducing unnecessary emergency department visits.[11] Digital health integration is another hallmark: Nearly all GP practices use electronic health records, and a national IT infrastructure enables secure data exchange across providers.[7,10]

Outcomes and successes The Netherlands consistently ranks among the world's top health systems, with life expectancy reaching about 81.9 years in 2024 (US Census) and low rates of avoidable hospital admissions. Primary care visits have no patient copayment, reinforcing equitable access.[10]

Australia

Australia's health system combines universal coverage with a strong primary care sector. Medicare, the national insurance scheme, covers all citizens and permanent residents for primary and hospital care. Most primary care is delivered by private GPs, but government financing and regulations promote universal access. About 86% of GP visits are "bulk-billed" directly to Medicare, meaning patients pay no out-of-pocket costs.[7] This reinforces affordability and equity.

Key strengths Australia emphasizes accessibility and workforce distribution. While there are no formal patient lists, individuals typically choose a regular GP, who acts as a gatekeeper for specialist care. To address rural and remote access, the government offers incentives for GPs to practice in underserved areas and supplements the workforce with internationally trained doctors. Primary Health Networks (PHNs) support local planning, chronic disease management and coordination. Australia also encourages multidisciplinary "super clinics" and the use of telehealth to extend primary care to sparsely populated areas.[7] These strategies reflect PHC principles of accessibility and community-oriented care.

Outcomes and successes Australia achieves excellent health outcomes, with life expectancy among the highest globally at about 83.5 years (US Census) and low mortality from preventable chronic diseases. Strong primary care underpins high childhood immunization rates and avoidable hospitalization rates better than the Organisation for Economic Co-operation and Development (OECD) averages. In a 2021 Commonwealth Fund assessment, Australia ranked third overall among 11 high-income countries.[8] Key to this performance is that Australia combines universal financial coverage with robust primary care delivery. Virtually all Australians can access a GP with minimal cost barriers, and continuity of care is fostered by long-term doctor-patient relationships. Ongoing reforms aim to further strengthen primary care – for example, introducing new digital health records and enhancing mental healthcare within GP settings.

New Zealand

New Zealand has a predominantly public healthcare system that provides universal coverage, with primary care as its foundation. General practice clinics are privately run but heavily subsidized by the government. Since the early 2000s, primary health organizations (PHOs) – local nonprofit networks funded via capitation – have organized primary care delivery for enrolled populations.[10] Most New Zealanders are enrolled with a PHO-affiliated GP, promoting continuity and GPs act as gatekeepers for specialist and hospital care.

Key strengths New Zealand's model emphasizes equity and affordability. Government subsidies keep copayments modest, with additional protections for vulnerable groups: Children under 14 receive free GP visits, and low-income adults pay reduced fees. Dedicated programs address Māori and Pacific health disparities, with community governance and Māori leadership integrated into planning.[10] PHOs encourage multidisciplinary teams and use shared electronic health records for coordination. There have also been performance incentive schemes, such as the PHO Performance Programme (PPP), which improved management of diabetes and cardiovascular risk at the primary care level. Innovations like after-hours GP telephone advice lines further enhance access and continuity.

Outcomes and successes New Zealand achieves strong health outcomes, with life expectancy around 82.9 years (US Census) and high uptake of preventive services like immunization and cancer screening. International comparisons place New Zealand in the upper tier for care processes, excelling in preventive and safe care.[8] By implementing capitation funding, reducing user fees and fostering community governance, New Zealand has aligned its primary care system closely with PHC principles of accessibility, continuity and community partnership. This approach delivers high-quality care for most of its population.

Denmark

Denmark's decentralized, tax-funded health system provides universal coverage with no patient fees for primary or hospital care. General practice is the cornerstone of care delivery: Every citizen is assigned or chooses a GP, and about 98% of the population adheres to this list system. GPs act as gatekeepers for specialist care, reinforcing continuity and coordination.[7]

Key strengths Denmark combines easy access with strong infrastructure. GPs typically work in small community-based clinics, and after-hours care is organized through regional GP cooperatives and a single medical helpline. Denmark is a global leader in health information technology (IT). All citizens have a unique health identifier. Nationwide electronic health records and e-prescriptions enable seamless information sharing.[7]

GPs and hospitals share clinical data, and patients can view records through a national e-health portal, improving transparency and safety. This reflects PHC principles of effective technology use and coordination.

Outcomes and successes Denmark has high life expectancy (around 81.2 years) (US Census), low avoidable hospital admissions and strong integration between primary care and municipal services for home nursing, rehabilitation and preventive visits. GPs support national screening programs, and recent policies promote closer health-social care integration. Investments in quality improvement and a culture of trust in primary care professionals help Denmark maintain one of the strongest PHC systems globally.[7]

Brazil

Brazil offers a leading example of PHC success in a middle-income country. Through its Unified Health System (SUS), Brazil has built one of the world's largest community-based PHC programs: the Family Health Strategy (Estratégia de Saúde da Família, ESF). By 2020, about 70% of Brazilians (over 150 million people) had access to Family Health Teams,[12] each serving a defined population with comprehensive, proactive care.[7]

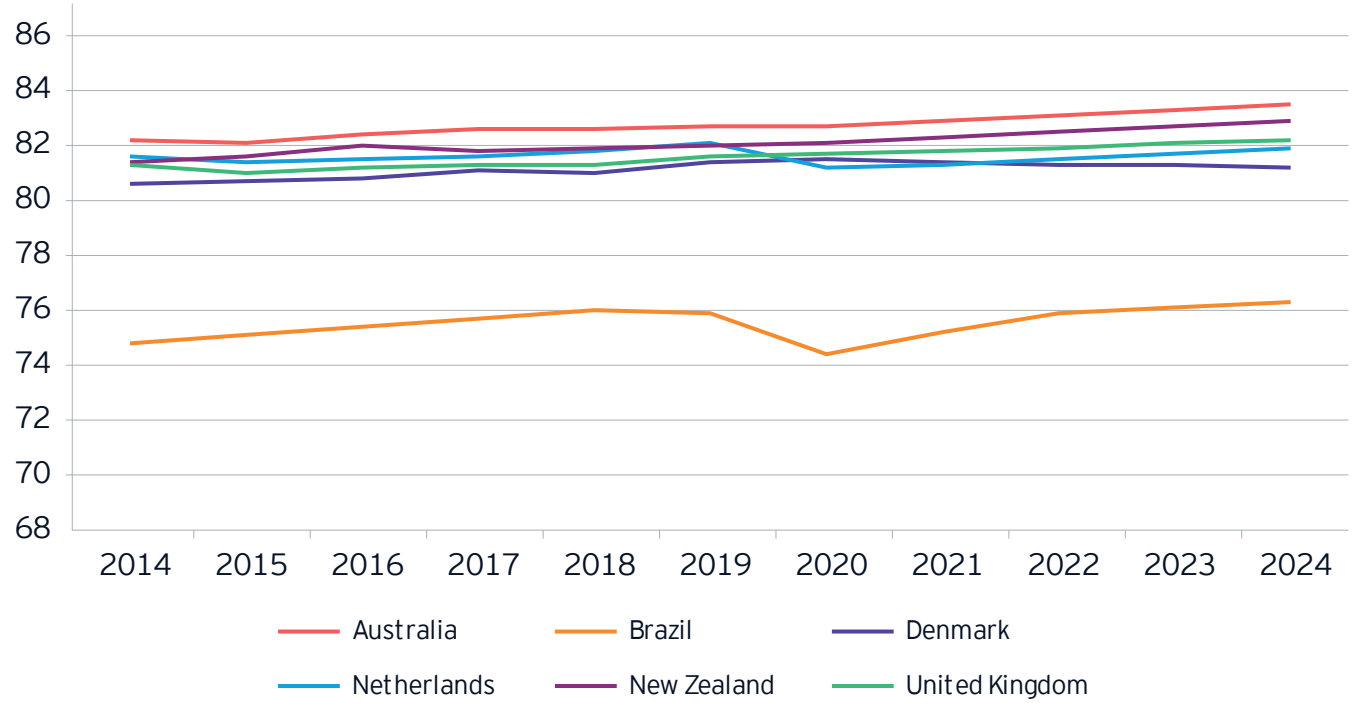
Key strengths The ESF is rooted in community orientation and equity. Multidisciplinary teams – typically a doctor, nurse, nurse assistant and several CHWs deliver preventive care, chronic disease management and home visits.[12] CHWs maintain close contact with households, enabling early intervention and health education. Services are free under SUS, eliminating financial barriers.[7]

Outcomes and successes The expansion of PHC in Brazil has driven major health gains: Infant mortality and deaths from conditions sensitive to primary care have fallen significantly,[12] and avoidable hospitalizations have dropped by up to 70% in areas with long-term ESF coverage.[7] Life expectancy rose to 76.3 years in 2024 (US Census), and health inequalities between rich and poor regions have narrowed.[13]

Across these six countries, common themes emerge that explain their world-leading performance in PHC. Universal coverage and low-cost barriers are fundamental from Britain's free-at-point-of-care NHS to Brazil's SUS. Each country guarantees access to primary care for the whole population, fostering equity. All six invest substantially in the primary care workforce and infrastructure, so that GPs or family health teams are available in all communities (with special efforts for rural or marginalized areas). They uphold core PHC functions: first-contact access for new health needs, person-focused continuity over time, comprehensive services and coordination of care.[9]

Innovations like pay for performance (P4P) incentives (UK's QOF, Brazil's Program for Improving Primary Care Access and Quality (PMAQ)), advanced health IT (Denmark's integrated records, Netherlands' digital exchanges) and after-hours service models (Netherlands' GP cooperatives, New Zealand's nurse triage lines) improve quality and responsiveness. Importantly, these countries continually adapt, integrating care across sectors, addressing social determinants and narrowing disparities, reaffirming the PHC approach as a dynamic, people-centered strategy for health.

Life expectancy — placeholder



Countries with strong primary care systems demonstrate better health outcomes, including higher life expectancies and lower rates of preventable diseases and hospitalizations. Top-performing health systems invest in accessible, high value primary care systems, which are linked to greater efficiency and equity.[8] Examples from the UK, Netherlands, Australia, New Zealand, Denmark and Brazil demonstrate that while models may vary (public or hybrid), success is driven by common principles: prioritizing primary care, supporting frontline providers and promoting patient-centered, accessible services. These Leading practices serve as valuable guidance for global health systems aiming to make primary care the foundation of sustainable, people-centered and integrated healthcare.

02

PHC worldwide: successes, gaps, future outlook and emerging trends

Current successes in PHC

Today, PHC is at the forefront of global health policy discussions, not only as a means to deliver essential services but also as a platform to address public health crises and social determinants of health. The COVID-19 pandemic underscored both the strengths and weaknesses of primary care. Strong PHC systems were better able to adapt, continuing essential services and aiding in early detection and response, whereas weaker systems left populations vulnerable.

As the world "builds back better" in the pandemic's aftermath, there is renewed momentum. This is exemplified by initiatives like the Global Coalition on PHC launched at the 2025 World Health Assembly, to reinvigorate political commitment and investment in primary care as the bedrock of resilient health systems.[14,15]

PHC has been central to major global health gains over recent decades. Key achievements include:

Expanded service coverage and preventive care

PHC programs have greatly increased access to essential services such as immunization, maternal and child health, and family planning. The Expanded Programme on Immunization (EPI), launched in 1974, boosted vaccination coverage from <5% of infants in the early 1970s to approximately 84% receiving three doses of diptheria, tetanus and pertussis (DTP) vaccine today. Vaccines delivered largely through PHC are estimated to have saved 154 million lives in the past 50 years, with measles vaccination alone accounting for 60% of lives saved. Other PHC interventions such as nutrition support, sanitation and malaria control (e.g., insecticide-treated bed nets) have also prevented millions of deaths.[16]

Improved health outcomes (mortality and longevity)

Investment in PHC is strongly linked to declines in maternal and child mortality. Since 1990, the under-five deaths have fallen by more than half (14.2 million in 1990 to 6.2 million in 2018), while maternal mortality dropped 38% between 2000 and 2017. These outcomes stem from wider access to skilled birth attendance, antenatal or postnatal care and management of childhood illnesses. Countries such as Bangladesh, Rwanda, Mongolia, Morocco and Cuba cut maternal and child deaths by strengthening PHC, training frontline workers and removing user fees.[17] The overall life expectancy has risen in many LMICs as PHC coverage expanded. Scaling up PHC in LMICs could save 60 million lives and add 3.7 years to global life expectancy by 2030.[6,14]

Equity and access

PHC prioritizes reaching the underserved populations, reducing health inequities. Ethiopia's deployment of tens of thousands of health extension workers and Brazil's ESF are examples of expanding services to rural and urban poor communities. PHC investments have consistently improved equity by lowering financial and geographic barriers.[14] Global Universal Health Coverage (UHC) reforms such as community-based insurance and free primary care initiatives have increased coverage for key services like vaccination, antenatal care, HIV and TB treatment.[18] Fewer households are now being pushed into poverty by health costs compared with the early 2000s.[18]

Cost-effectiveness and efficiency

PHC emphasizes prevention and early intervention, reducing costly hospitalizations. The WHO considers PHC the most cost-effective way to organize health systems.[14] CHWs exemplify this efficiency, expanding coverage at low cost and improving outcomes.[19] Countries including Nepal, Bangladesh and Malawi have shown how CHWs and community volunteers deliver maternal and child services with high impact and low cost. Strong PHC systems also manage chronic conditions more cheaply in the community, reducing overall health system expenditure.

Disease control and public health achievements

PHC networks have driven major public health victories. Polio cases have dropped by 99.9% due to community-level vaccination, while routine immunization has eliminated or drastically reduced diseases like diphtheria, measles and tetanus in many regions.[16] The scale-up of HIV treatment and community-based tuberculosis control relied heavily on PHC. Recent breakthroughs such as malaria and HPV vaccination also depend on PHC delivery.

Health security and pandemic response

The COVID-19 crisis highlighted PHC's role in resilience. Strong PHC systems maintained essential services, supported testing and surveillance, and managed mild cases, easing pressure on hospitals. In countries like Thailand and Vietnam, local health volunteers were central to outbreak detection and community response. PHC's adaptability has reinforced its importance in health security and emergency preparedness.[14]

Global political commitment

PHC has gained renewed political prominence. The 2018 Astana Declaration reaffirmed PHC as the path to universal health coverage. By 2025, a coalition of 18+ countries was championing PHC reforms and sharing best practice.[14] This momentum has translated into new PHC strategies, funding commitments and policies such as free primary care for vulnerable groups and integration of vertical programs into comprehensive PHC.

PHC has driven major global health improvements — reducing child mortality, increasing life expectancy and controlling endemic diseases, while promoting equity and cost-effectiveness. However, significant gaps remain in access, quality and funding.

Persistent gaps and challenges in PHC

Despite notable successes, PHC faces systemic challenges that undermine its potential. Key gaps include:

Inadequate access and coverage

Half of the world's population still lacks access to the essential health services.[6] Rural, remote and conflict-affected areas remain underserved due to geography, staff shortages or limited services. Even where facilities exist, many lack comprehensive care such as mental health or advanced diagnostics. Inequalities are stark: In low-and lower-middle-income countries, only 17% of mothers and children in the poorest quintile received a package of seven basic interventions, compared with 74% in the richest quintile. Children in sub-Saharan Africa and the poorest households are least likely to access essential services.[17,18] While coverage of immunizations and antenatal care is relatively high, chronic disease management and geriatric care lag far behind. Closing these gaps, particularly for vulnerable groups, is a major challenge.

Workforce shortages and maldistribution

The WHO projects a global shortfall of 10 to 11 million health workers by 2030, primarily in low-and lower-middle-income countries, while other estimates suggest 18 million additional workers will be needed (10 million in PHC).[6] Clinics often lack sufficient staff, and urban centers attract more providers than rural communities. Training is often hospital-focused, leaving gaps in primary care competencies. Workforce retention is another persistent issue. Many health professionals migrate from poorer to wealthier regions and countries, while budget constraints leave some trained

staff unemployed. High-income countries also face crises of burnout, workload and aging workforces, with many physicians planning early retirement.[20] Without adequate, well-distributed and motivated providers, PHC cannot deliver comprehensive, high-quality care or reach underserved populations.

Insufficient financing and high out-of-pocket costs

PHC is chronically underfunded, with most resources directed toward hospitals and specialist care. Many low-income countries spend minimal amounts on PHC, leaving facilities under-equipped and staff underpaid. Globally, 800 million people spend over 10% of household budgets on health, and 100 million are pushed into extreme poverty annually due to medical costs. Out-of-pocket payments, user fees and lack of insurance remain barriers. Donor funding often flows to vertical programs, bypassing broader PHC strengthening. In high-income countries, fee-for-service models undervalue primary care consultations. WHO recommends governments allocate at least 1% of gross domestic product (GDP) to PHC to close service gaps.[6] Without increased investment, PHC cannot deliver quality or equitable care.

Variable quality of care

Poor-quality care accounts for more avoidable deaths in LMICs than lack of access. Around 60% of deaths from conditions requiring healthcare are linked to poor quality, versus 40% from lack of access.[14] Globally, five to eight million lives are lost annually due to substandard care even among those who seek services.[21] Common issues include misdiagnosis, unsafe treatment, lack of medicines and equipment, weak referral systems and poor continuity of care. Negative patient experiences such as short consultations and disrespectful care erode trust and drive people away from PHC.[19] Quality improvement systems are often weak, with little training, supervision or adherence to guidelines. Raising care quality is as urgent as expanding access.

Changing disease burden and limited-service scope

PHC has not fully adapted to rising non-communicable diseases (NCDs) and mental health needs. Many clinics lack diagnostic tools, medicines or trained staff for hypertension, diabetes and other chronic diseases. Mental healthcare is especially weak, despite WHO's Mental Health Gap Action Programme (mhGAP) initiative. Geriatric needs including frailty, dementia and multi-morbidity are under-addressed, particularly in rapidly aging societies. Services like palliative or dental care are rarely integrated into PHC. In high-income countries, after-hours and home-based services are insufficient, leading to avoidable hospitalizations. Expanding PHC's scope to meet these evolving needs is critical.

Fragmentation and weak referral systems

In many systems, patients bypass PHC to seek hospital or specialist care directly, undermining PHC's role. Where PHC does act as gatekeeper, referral pathways are often weak, with poor communication between clinics and hospitals. Vertical disease programs (e.g., HIV, TB, immunization) sometimes duplicate or fragment care. Health records are frequently siloed, disrupting continuity. Integration with public health functions (surveillance, health promotion) is also limited. A strong referral system and integrated health information are essential to improving care coordination.[19]

Social and environmental determinants

PHC aspires to address underlying determinants such as water, sanitation, education, housing and nutrition but often lacks mandate, resources or cross-sectoral coordination. Poor living conditions and inequities undermine health outcomes even when services exist. Some countries such as Rwanda and Thailand have integrated PHC with social programs; however, most have not. Climate change and environmental hazards pose new challenges such as extreme weather and disease outbreaks that PHC is ill-prepared to manage. The gap between PHC's intersectoral vision and current capacity remains wide.[14]

Although PHC offers clear benefits, major challenges, such as limited coverage, financial strain and system inefficiencies have hindered progress toward UHC. Since 2015, service expansion has stalled, and financial protection has declined in some regions. A 2023 global monitoring report highlights rising catastrophic health spending and slow advancement toward UHC, a key target under Sustainable Development Goal 3 (SDG 3.8). Closing these gaps is critical to realizing PHC's full potential.

The future of PHC: vision and outlook

The future of PHC: vision and emerging trends

The future of PHC is envisioned as more people-centered, technology-enabled, equitable and resilient. Building on lessons from past decades and the COVID-19 pandemic, stakeholders agree that strong PHC must be the foundation of sustainable health systems. Below, we outline the key directions shaping PHC's evolution, each representing both an aspirational vision and an observable trend.

1 From fragmented services to person-centered integrated care

Health systems are moving away from disease- or hospital-centered models toward holistic, people-centered PHC.[14] Primary care is set to become the hub of integrated service delivery — covering preventive, curative, rehabilitative and palliative care with smooth referral pathways to specialists when needed. PHC will also take on stronger public health roles, such as health education, immunization and surveillance, while linking with social services to address determinants like nutrition, housing and welfare. In practice, this could mean a "one-stop" community clinic where most health needs are met locally, coordinated by a multidisciplinary team. This integrated approach should improve continuity, patient trust and efficiency.

2 Equity and "leaving no one behind"

Future PHC will prioritize reaching underserved populations — rural, remote, urban slum and marginalized groups. Strategies include deploying more CHWs, expanding mobile clinics and leveraging technology such as telehealth or drone delivery of supplies. Financial protection is central, and policies aimed at reducing out-of-pocket costs, expanding insurance to cover outpatient care and offering free PHC for vulnerable groups are gaining ground. Equity-focused planning such as allocating resources to disadvantaged districts or disaggregating data to track disparities will guide implementation.[6] The "leave no one behind" agenda of the SDGs requires PHC to be the frontline mechanism for reducing inequities.

3 Digital health and artificial intelligence

The digital revolution is reshaping PHC. Telemedicine, catalyzed by the COVID-19 pandemic, with a reported 766% surge during the pandemic,[22] is now a permanent feature of primary care. Mobile health apps help patients manage chronic conditions, while electronic health records and interoperable systems are expanding continuity of care. Artificial intelligence (AI) and big data will increasingly support clinical decisions, interpret images, enable predictive analytics for population health and automate administrative tasks to reduce provider burden. Early evidence shows AI "scribes" can mitigate burnout, and future systems may even support personalized care based on genetics or wearables.[23] Policymakers are working on regulatory frameworks so that safety, equity and privacy are upheld in this digital transformation.[24,25]

4 Strengthening the workforce and team-based care

The PHC workforce of the future will be larger, more diverse and more equitably distributed. Task-sharing and team-based models are key: Physicians will increasingly work alongside nurses, CHWs, pharmacists, social workers and mental health counselors. CHWs will be more professionalized, integrated and supported — bridging cultural and logistical gaps between clinics and households. Nurse practitioners and physician assistants will assume expanded clinical roles in many systems, while pharmacists and paramedics contribute to preventive and home-based care. Training will emphasize chronic disease management, geriatrics and mental health. Technology will also support workforce expansion — for instance, decision-support apps enabling CHWs to manage hypertension or depression. Crucially, policies

must address workforce wellbeing, burnout and rural distribution, with global targets such as creating 10 million new health worker jobs to close the 18 million shortfalls by 2030.[6]

5 Financing PHC as a high-value investment

Underinvestment in PHC remains a critical barrier. However, the outlook is shifting. WHO recommends that countries allocate at least 1% of GDP to PHC.[6] Financing reforms under consideration include capitation and performance-based payments that reward outcomes rather than service volume, along with expansion of universal insurance packages that cover outpatient care and medicines. Donors are also directing more funds to health system strengthening. Public-private partnerships and contracting non-governmental organizations (NGOs) for service delivery are growing in some regions. Evidence shows that PHC investment has exceptional returns — up to 75% of health gains from the SDGs could be achieved through PHC.[14] Future financing must position PHC as a strategic, high-value investment rather than a budgetary afterthought.

6 Quality, outcomes and accountability

Future PHC will be judged not only by access but also by the quality of care delivered. Poor-quality services currently account for more avoidable deaths than lack of access in LMICs.[21] The future response includes standardized clinical guidelines, continuous provider training, accreditation systems and performance monitoring. Data systems will track outcomes such as blood pressure control rates, diabetes management, immunization coverage and patient satisfaction. Models of value-based care may link provider funding to health outcomes. The patient voice is also expected to grow, with community oversight and patient feedback platforms gaining traction. Together, these trends aim to achieve the "quadruple aim": better outcomes, better patient experience, lower costs and better provider wellbeing.

7 Resilience, preparedness and climate adaptation

The COVID-19 pandemic underscored the role of PHC as the frontline of health security. Future PHC must be able to detect and respond to outbreaks quickly while maintaining essential services. Preparedness includes training staff in emergency protocols, stockpiling supplies and integrating PHC into national resilience plans. Telehealth and flexible service delivery will buffer against future disruptions. Climate change introduces additional challenges; PHC facilities may lead community education on heat risks, vector-borne diseases and disaster response. "Green PHC" initiatives, such as solar-powered clinics or waste reduction efforts, are emerging as part of global sustainability agendas. PHC's close community ties position it as central to resilience-building in the face of health and environmental crises.[14]

The future of PHC is promising and within reach. With proper investment and reform, PHC can deliver equitable, high-quality, person-centered care that integrates technology with human connection. Emerging trends signal a transformative decade, positioning PHC as the foundation of universal health coverage and resilient health systems.

Strategic recommendations for strengthening PHC

To sustain successes, close gaps and prepare for future needs, governments and stakeholders should act across the following priority areas:

1 Increase investment in PHC

To reinforce the foundation of effective health systems, it is imperative to increase financing for PHC by at least 1% of gross domestic product (GDP), in line with the WHO's recommendation. Protecting PHC budgets from cuts during fiscal downturns is vital for the sustainability of services and the continuity of care for all populations.

Strategic allocation of resources should prioritize the upgrade and modernization of clinics, particularly in underserved and marginalized areas. Investments must also be directed toward securing uninterrupted access to essential medicines and vaccines. Additionally, financial protection measures should be strengthened to shield vulnerable and low-income groups from out-of-pocket expenses, thereby promoting equity and universal access to care.

UHC packages should include comprehensive primary care with little or no copayment. Innovative payment models such as capitation, performance-based incentives, can align funding with population needs. Scaling up PHC in LMICs alone could save 60 million lives by 2030.[6]

2 Build and sustain the PHC workforce

To sustain the PHC workforce, it is important to address the global shortfall through large-scale recruitment of general practitioners, family medicine nurses, midwives and community health workers. In addition, comprehensive training programs should be prioritized to ensure these professionals are well-prepared to meet diverse healthcare needs. Expand education pathways, scholarships and career incentives, especially for service in rural and underserved areas. Adopt task-sharing policies with proper training and supervision, aiming to create at least 10 million new frontline jobs by 2030. Support retention through fair pay, so that gender pay equity, safe working conditions, professional development and leadership opportunities for women – who comprise approximately 70% of the workforce[6] – are maintained.

3 Strengthen infrastructure and supplies

Facilities should be upgraded to include reliable water, power, sanitation and designs that accommodate individuals with disabilities. Promote uninterrupted access to essential medicines, vaccines and diagnostics through stronger supply chains and digital logistics systems. Expand rapid diagnostic capacity and point-of-care testing to enable same-day diagnosis and treatment. Equip clinics with protective gear and digital connectivity, including computers, internet and mobile links to support resilient, modernized PHC delivery.

4 Leverage technology and innovation

Governments should implement national digital health strategies that fully integrate primary healthcare, including the adoption of electronic health records, telemedicine services and e-prescribing systems. Additionally, train providers in digital competencies[6] and expand internet and broadband access to prevent widening inequities. Pilot AI-based triage and decision-support tools under strict oversight, protecting patient privacy and security with robust governance measures. This supports the responsible integration of technology, maintains trust, and safeguards sensitive information. International partners can assist through open-source digital solutions and knowledge-sharing.

5 Focus on quality and continuous improvement

Establish PHC-level quality improvement (QI) programs that incorporate evidence-based protocols, staff training, supportive supervision and the use of performance data. Track key indicators, such as immunization coverage, blood pressure control and wait times, and take action based on results. Foster a culture of safety and patient-centeredness through tools like checklists and patient feedback. Consider implementing accreditation or external certification. Continuous professional development and peer learning should be embedded in the system. Poor quality can be as deadly as lack of access;[14] therefore, prioritizing quality is essential.

6 Strengthen governance and policy support

Translate high-level political commitment into actionable national PHC strategies with clear targets for service delivery, financing and workforce. Additionally, establish dedicated PHC units within ministries, reform regulations (e.g., task-sharing, telehealth), and eliminate barriers such as informal fees and corruption. Further, institutionalize intersectoral collaboration on social determinants[14] and decentralize decision-making to local managers with accountability. In parallel. promote community oversight through health committees or boards. Finally, at the global level, countries should remain engaged in coalitions like the Global PHC Coalition to align reforms and share lessons.

7 Promote community engagement and empowerment

Place communities at the heart of PHC through health committees, forums and education campaigns in local languages. Additionally, improve health literacy so people use services appropriately and manage their own conditions, such as self-monitoring blood pressure. Moreover, link PHC with community groups, schools and women's and youth networks for prevention and early action. Empower CHWs as both service providers and liaisons. Building cultural competence and trust is essential for promoting uptake, especially in marginalized populations.

8 Promote monitoring, learning and adaptation

Adopt a learning approach by tracking metrics such as the PHC service coverage index, satisfaction and financial protection. Additionally, use these results to adjust strategies and scale up effective innovations. Encourage operational research and pilot projects, rigorously evaluate outcomes and adapt for context. Share experiences through South-South learning and WHO platforms to accelerate collective progress.[26] Ultimately, treat PHC strengthening as an iterative process – data-driven, evidence-based and adaptive.

Conclusion

PHC has indisputably proven itself as the backbone of effective health systems, with decades of evidence showing its ability to save lives, prevent disease and promote equity. Countries that invested early in PHC such as Costa Rica, Cuba, Sri Lanka and Kerala in India achieved outcomes rivaling those of wealthier nations. This strongly supports the claim that PHC is a driver, and not merely a correlate of better population health. PHC-oriented systems deliver better outcomes at lower costs, avoiding unnecessary hospitalizations, managing chronic diseases in the community and detecting outbreaks early through trusted, local networks. These strengths make PHC not only a moral imperative for equity but also a strategic investment, offering high economic returns through healthier populations and reduced long-term costs.

Yet, as of 2025, major gaps remain in access, workforce, financing and quality. The rise of chronic diseases, persistent inequities and new threats such as pandemics test the adaptability of PHC systems worldwide. Political will, resource reallocation and systemic reforms are required to overcome entrenched barriers, including underfunding, workforce shortages and misaligned payment models. Strengthening PHC demands continuous investment in infrastructure, community participation and technology, alongside incentive reforms to attract and retain frontline providers.

Looking ahead, the future of PHC lies in hybrid care models that combine in-person and digital services, data-driven personalization for preventive and chronic care, and community-centric approaches that embed health within local contexts. Countries must invest in workforce development, equity-focused financing and responsible technology use to strengthen trust and accessibility. Performance-based incentives, team-based care and innovations like telehealth and shared electronic records can enhance efficiency without eroding the human connection that underpins primary care.

The vision for the future is a PHC system that is comprehensive, continuous and close to home, where no one is denied care due to cost or distance, and where communities are active partners in health. If countries sustain reforms — expanding investment, training health workers, adopting hybrid digital models and integrating PHC with public health surveillance — the benefits will be tangible. These benefits include more children immunized, chronic diseases better managed, families protected from financial hardship and hospitals freed to focus on complex care.

Ultimately, PHC is both the oldest and most forward-looking approach to health. It is rooted in community care yet vital for achieving universal health coverage, sustainable development and global health security. The evidence is clear, and the principles are proven. The challenge now is to act with resolve and urgency to make PHC the foundation of health systems everywhere.

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