

January
2019



Discussions around Primary Health Care and the Private Sector during the Global Symposia on Health Systems Research 2018

Dr Kim Ozano, Professor Padam Simkhada, Dr Lorna Porcellato and Rose Khatri

Acknowledgements

We would like to thank all the rapporteurs who took part in the weeklong training in preparation for the conference data capture process and interviews. The dedication and professionalism of the students (and two consultants) was exceptional and we could not have collected the quality of data without this. Representing over 13 countries, the rapporteurs in alphabetical order were: Swosti Acharya, Banin Ali, Sapana Basnet Bista, Elvis Chem, Ruth Cross, Emily Doncaster, Anne Marie Dukuzimana, Temitope Fatoki, Matthew Hibbert, Alice Hillis, Ashibudike Idebolo, Ema Kelly, Sheba Titus Livingstone, Efe Mamuzo, Deqa Muse, Chikondi Mwendera, Bevis Phiri, Hamda Sandison, Pippa Sargent, Chipego Siamuwele, Manisha Singh, Pasang Tamang, Laxmi Timalisina, and Aminu Umar.

Thanks to HSG for sponsoring the rapporteur's attendance at the conference. They have all reflected on how much they gained from the experience and how it has inspired them to progress their careers in international health.

Finally, thanks to the Bill and Melinda Gates Foundation (BMFG) for the financial support for this project.

Although the report was produced with financial support from HSG and BMGF the views reflected in the report do not represent the views of these entities.

Abbreviations

ANC	Ante Natal Care
ASHAS	Traditional CHW in India
BPHS	Basic Package of health Services
CHS	Community Health System
CHW	Community Health Workers
EPHS	Essential Package of Health Services
FBHP	Faith Based Health Providers
FBO	Faith Based Organisations
HRH	Human Resources for Health
HMIS	Health Management Information System
ICT	Information Communication Technology
IP	Indigenous Populations
LJMU	Liverpool John Moores University
LMIC	Lower and Middle-Income Countries
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MOH	Ministry of Health
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisations
OOPE	Out of Pocket Expenditure
PHC	Primary Health Care
PHCPI	Primary Health Care Performance Initiative
PPP	Public-Private Partnerships
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goals
SDOH	Social determinants of Health
SSA	Sub-Saharan Africa
TBA	Traditional Birth Attendant
UHC	Universal Health Coverage
WHO	World Health Organisation

Contents

Acknowledgements.....	2
Executive Summary.....	5
Introduction and Methodology	12
Findings	13
How to Achieve Comprehensive Primary Health Care (PHC) and Universal Health Coverage?.....	13
Political Advocacy for Comprehensive PHC.....	14
Planning and Prioritisation Models.....	15
Decentralisation and Devolution	16
Integrating NCDs	17
Changing and Emerging Context matters, But What Does This mean for PHC and UHC?	18
Fragile and Conflict Affected states	18
Urbanisation.....	20
Governance, Leadership and Accountability	21
Strong Leadership and Commitment.....	21
Accountability, Transparency and Responsiveness of PHC systems.....	23
Collaborations and Multisectoral Working.....	23
Scale Up.....	24
Financial Planning and Management.....	25
Financial Risk Protection	26
What is the UHC Price Tag?	28
Human Resources for Health	29
Quality.....	31
Challenges	31
Solutions & Areas of Good Practice	31
Quality Measures	32
Community Health Systems.....	33
Community Engagement & Empowerment.....	35
Equity	36
Data, Monitoring and Evaluation.....	37
Monitoring and evaluation approaches.....	38
Private sector	39
Regulation and Quality within the Private Sector.....	40
NGOs and Faith Based Organisations	42
Conclusions and Final Thoughts.....	44
References	45
Appendix 1 – Data Capture Framework.....	46

Executive Summary

The aim of this report is to provide an overview of core discussions around Primary Health Care (PHC) and the Private Sector, which took place during the 5th Global Symposium on Health Systems Research 2018: Advancing health systems for all in the SDG era. Universal Health Coverage (UHC) and how health systems are working to deliver this global goal by 2030 was a major theme of the conference. Conference sub-themes revolved around broad topics of: Multi-sectoral Action; Engaging the Private Sector; Leaving No-one Behind and Community Health Systems. Discussions were captured through two core methods: 'in session data capture' and semi-structured interviews. 26 conference rapporteurs captured data in 93 sessions; and 21 interviews were conducted with policy makers, implementers and practitioners from the public and private sector. The findings are mainly focused on research from low and middle-income countries (LMIC) with some examples from upper middle and high-income countries. This focus was chosen as the opportunities to promote and report health research from resource-poor settings is limited (Siriwardhana, 2015). The conference provided an opportunity for shared learning due to the many scholarships that supported attendance of health actors and researchers from LMICs. Ethical clearance was obtained from the Liverpool John Moores University (LJMU) Ethics Committee. The following broad themes were identified through data capture and interviews. Findings that are more detailed can be located in the main body of the report and include case study examples.

How to Achieve Comprehensive Primary Health Care (PHC) and Universal Health Coverage?

The conference demonstrated the complexity and variety of health systems with countries at various stages of implementation, reacting to their own interpretations of both UHC and PHC. All countries are developing or modifying their health systems to achieve UHC and key questions around where to invest and how to achieve good value for money without compromising effectiveness and quality were often at the heart of discussions. PHC is recognised as the most cost-effective method of delivering broad population based health services, though different models exist. In LMICs, these are often referred to as community health systems (CHS), which dominate in rural areas. In upper-middle income (UMIC) and high-income countries (HIC) these are often General Practitioner (GP) led or known as primary care services. In many urban settings in LMICs there is no PHC system to speak of, rather a plethora of small clinics and pharmacies which focus on disease and treatment. There is a burgeoning consensus that vertical disease programmes hinder development of broader horizontal PHC systems, particularly in LMICs.

Across presentations unanswered questions posed by presenters and interviewees included: what is the fairest way to distribute scarce health resources and where to start? Do you address the context specific burden of disease and change the PHC system to meet these? On the other hand, do you focus on horizontal comprehensive PHC systems based on the Alma Ata model? There are also externalities to consider, if you train staff in one disease area can it be translated and improve performance in others? The MDGs have provided a platform for building on the SDGs but health leaders are struggling with how to reorient health systems towards a comprehensive model of PHC that can integrate the SDOH and particularly the prevention and management of NCDs.

There is still a political bias towards biomedicine and delivering clinical services, which health sector leaders and implementers of PHC are challenging. Driven by both the demand and supply side, providing clinical and hospital-based care is viewed as a vote winner across most political systems. This suits the private for-profit sector as it focuses on secondary and tertiary care and disease rather than prevention and health promotion. The broader public health approach through PHC is being squeezed out of the decision making process. This suggests that the research-policy nexus needs strengthening, and that evidence has to be translated into practical solutions so that policy makers gain a clearer understanding of the research findings. Researchers need to understand the policy and decision-making process in more depth and provide timely evidence during 'windows of opportunity'.

Some examples of practical solutions include; political advocacy through communicating information and evidence to citizens and communities to drive priority setting and PHC reforms, presenting evidence to policy makers and politicians as a business case with cost effectiveness built in and sharing models and success stories from other countries. However, evidence from other countries was only reported as valuable when it is from a country with a similar context and historical experience.

Access to good quality demographic and epidemiological data is critical for decision makers at all levels of the health system. Data should also include community health needs and quality related indicators. However, there are reported challenges in collecting good quality accurate data and analysing, interpreting and using it for planning which is a reported gap in many PHC systems. There are a number of tools being trialled to reduce inequities in health and access to PHC and to enhance planning. These include the Urban Health Equity Assessment and Response Tool (Urban HEART) which was piloted across a number of cities in the Philippines, Sri Lanka and Kenya and the Urban Health Atlas (UHA), developed and applied in Bangladesh. In South Sudan and Madagascar, the Community Health Planning and Costing Tool was used to support the planning and costing of effective community health services packages.

The challenges of integrating multiple interventions and programmes into PHC was a key discussion point across many presentations. For example, health systems financing was reported as an obstacle to integrating NCDs into PHC as finances for services remain donor driven and provided for specific vertical programmes like HIV/AIDS and Tuberculosis (TB). As such, whilst the will for integration is there, the skills and resources are not. However, some evidence indicated that international aid is becoming more flexible towards supporting health system development and recognising the need to move away from vertical funding streams that restrict this.

Recommendations: Produce guidance and discussion platforms to support policy makers and implementers to re-orient current verticalized health systems towards a comprehensive model of PHC that allows for integration of social determinants of health (SDOH). Improve data collection and analysis to provide evidence of PHC as a cost-effective solution to health challenges. Use tools that have been tried and tested in similar contexts to build a solid business case for PHC and work with politicians, policy makers and civil society to sell the idea. Include non-health actors in the process.

Governance, Leadership and Accountability

Developing a robust PHC system to achieve UHC requires good governance, strong leadership and accountability. In most global strategies, there is an emphasis on governments taking a leadership role in protecting, maintaining and promoting the health of their populations; however, there is a reported gap in leadership and management competencies needed to build resilient and responsive PHC in LMICs. The decentralisation/devolution of health planning and decision-making is an important element of governance and enhancing accountability. Whilst overarching health policy ambitions should be developed nationally, it is critical that planning for PHC is implemented at the local and community level to ensure that community needs are included and addressed. Community participation in priority setting for PHC has gained importance globally, particularly in resource-poor settings. It is a major principle of people centred health systems, highlighting the intrinsic value and strategic importance of assessing community needs and assets.

The conference provided a number of methods to increase accountability to communities. These included; engaging civil society, community scorecards, health facility and district level councils and committees and through CHWs. Other public engagement tools included using the media, radio, surveys and interviews following service experiences, photos, exhibitions, and a community assembly for complaints with a health professional present. Kenya provided examples of Council Health Service Boards and Health Facility Governing Committees. However, citizen participation (Kenya, Ghana,

Ethiopia, Tanzania) in priority setting and holding PHC services accountable by those who receive them is challenging because of a lack of capacity and opportunity to voice their needs, especially with vulnerable populations. The use of participatory action research (PAR) cycles and participatory planning processes to improve quality and promote joint solution finding is a more inclusive method and has been successfully used in a number of countries, including Cameroon, Nigeria and Uganda.

Multi-sectoral collaboration and partnerships between actors/agencies, regarded as essential to UHC, requires the identification of clear roles and leadership. Some key features of good partnership working were noted including: trusting relationships, pooled procurement and funding, adopting broad and shared frameworks to ensure a common understanding of technical concepts, build consensus and ensure ownership and long-term political sustainability. In addition, shared goals and outcomes, shared learning to strengthen capacity, identified champions, and having strategic figures at state and national level to drive the partnerships.

Recommendations: Provide opportunities for government leaders and implementers to develop competencies related to leadership, management and partnership working for the delivery of PHC services. Support the development of legal frameworks of governance and regulatory measures that protect and include the public and local level authorities in PHC accountability.

Cost of UHC, Health Expenditure and Financial Planning

Government capacity in LMICs for financial planning and strategic purchasing is often weak in health systems at all levels. Attaining affordable quality products and equipment means that negotiation skills are needed to get discounts on drugs, consumables and equipment. Pooled procurement and an inventory management system were suggested as best practice. One suggestion was that regions should work together to agree on purchasing and regulation to gain power and negotiating strength. Suggestions from presenters and the audience to improve funding flows included pooling funds through better-coordinated aid investment, supporting routine performance and financing reforms through strategic purchasing that is demand driven and strengthening links between the Ministry of Health, PHC departments and the Ministry of Finance.

Stewardship capacity for contracting was reported to be weak, lacking in specialised staff and support systems for writing, pricing and tendering contracts and there was a lack of understanding of how to undertake fair and responsible contracting agreements. Concerns were raised from providers about timely repayment, low reimbursement rate and rising empanelment standards, which are particularly challenging for facilities/services in resource-deprived areas. Providers were also reported as being unsure as to what can be covered due to unclear policy guidelines/price discrepancies. In some cases, the private sector had lost interest over time due to long tedious tendering processes.

Catastrophic spending because of out of pocket payments for health services was raised as a major issue in many presentations, especially within LMICs and for the poorest populations. Health insurance schemes are being presented as the answer to catastrophic health spending, however some schemes are a potential risk for PHC, especially for the poor, as they are often the people not enrolled. Suggested ways to improve enrolment were; designing marketing techniques targeted towards lower literacy groups, matching premium collection time with income flow and excluding some pre-existing conditions of potential clients until the scheme reaches financial stability. Currently many insurance schemes are only focused on secondary and tertiary services and not on PHC.

The majority of the cost of SDG 3 is at the PHC level but the price tag is unknown. PHC components can be identified but challenges reported were in defining what services to include, variation in country service delivery, no clear PHC definition, no standard instrument for PHC measures and data coming from various sources which makes systematic analysis challenging. Measuring the cost of UHC

and the most effective methods to finance will continue to be a big challenge. There will not be a one size fits all solution. Every country must develop or adapt existing methods, which are acceptable to the population.

Recommendations: Develop and share knowledge, skills and tools of financial planning and procurement processes. Develop innovative methods to promote health insurance schemes to populations especially those most vulnerable. Identify insurance schemes, which subsidise the poorest sectors of society.

Human Resources for Health

Human resources challenges cut across presentations and were often related to discussions about achieving high quality health care. Workforce shortages from 'brain drain' to the private sector and migration out of LMICs were reported in numerous sessions. Public sector workers 'retire' early to work in the private sector as reported in India and South Africa because of; better management of staff and higher morale, monthly salaries provided on time, opportunities to learn, and more job satisfaction. This health workforce drain from public services increases the workload of others and means more 'patients' and less time. This is compounded by late or failure to pay health service providers and limited career progression opportunities. The outcomes of workforce shortages reported within the presentations were; persistent absenteeism and poor attitudes of health staff that result in decreased health seeking behaviour and reliance on traditional healers. Innovative solutions are required to attract and sustain health workers in country and particularly in rural areas. Measuring and estimating the level of health worker gaps is a challenge. The lack of knowledge of where staff are at any given time means that facilities either could be over or under staffed. In addition, presenters called for more data regarding the financial resources necessary to incentivize, supervise, and provide logistical support to health workers.

A number of solutions emerged from the conference, which included strengthening PHC staff capacity to lead and manage facilities and services, task shifting, Continuing Professional Development (CPD), IT and EHealth innovations. In Kenya and Uganda, incentive frameworks were applied to support health workers to work in areas that were under-resourced. This has helped attract and retain people. Integrated Information, Communication and Technology (ICT) solutions can strengthen health worker effectiveness and mobile technology has potential for enhancing capacities, empowering and managing a large workforce like CHWs. In Northern Uganda, IT systems were employed to monitor and evaluate health worker attendance.

Recommendations: Establish and/or share existing innovative mechanisms to monitor PHC staff capacity for managing and delivering quality PHC services and the geographical distribution and movement of workers. Produce guidance for financial planning of PHC HRH that includes supervision, logistical support and sufficient professional development opportunities. Consider the use of technologies to support managing large workforces. Increase training of local people in specific tasks to serve their communities.

Quality

There were numerous references throughout the conference to 'quality' as a key element in the strengthening of health systems and improving health worker performance. As someone eloquently put it, *'there will be no UHC without quality' (Data capture)*. Quality issues ranged from data collection, to improving times of clinics to deeper conceptual considerations of safe practice and providing care that is respectful and equitable. Staff training is a critical element in improving the quality of care, but this increases cost and puts pressure on staffing levels in health facilities. Quality care must be safe

care, and this can be challenging in LMICs where there is little regulation of health worker practice and qualification.

A key take home message was that improvement of health outcomes, health systems and health worker performance cannot be achieved without a focus on quality measures and management. A number of key actions have to take place before quality measures can be cascaded to facility level.

Recommendations: The concept of quality must be developed and owned by all levels of the health system and those working in it. Developing a culture of quality is key and Kenya provides a good example of embedding quality measures through the SQALE project. Promote 'quality champions' at all levels of government including and starting with the MOH.

Changing and Emerging Contexts Matter, But What Does It Mean for PHC and UHC?

The impact of conflict, protracted conflict and fragile states on establishing PHC and reaching UHC cut across several presentations and group discussions. Fragile states are increasing, with approximately 60% of people from UMICs and LMICs living in fragile states that are disruptive and have complex consequences on health systems. War results in injuries, delayed medical supplies, displacement, self-medication and psychological trauma, which are then transferred to neighbouring countries and communities as refugees flee to safe areas. In addition, attacks on health infrastructure and staff, including CHWs pose additional risks. Conflict affected states (e.g. Syria) mean that hundreds of thousands of people flee to neighbouring countries (Lebanon, Jordan, Turkey) with physical and mental health challenges including over-crowding in temporary shelters, high risk of disease outbreaks and stress in surrounding communities. Health facilities at borders are not able to meet refugee PHC needs due to limited human resources, stigma, fear and a lack of mental health awareness and skills.

In areas with protracted conflict, for example Sudan, Somalia and Uganda, health systems are increasingly disrupted and fragmented. Ineffective functionality of leadership and governance structures at community, health facility and district levels hinder the ability to monitor and provide health services. In addition, challenges in attracting and retaining health workers due to poor infrastructure, insufficient equipment, inadequate social amenities and poor pay resulting in poor health worker-population ratio compared to other regions of the country.

Growing urbanisation has raised the need for better understanding of how to manage the complexities of PHC in urban environments that are not homogenous. Research and interventions have tended to focus more on rural settings, thus leaving a gap in knowledge related to delivering PHC in the urban context. Urban settings have multiple uncoordinated and unregulated structures and a range of profit and not for profit private sector providers, which is increasing inequities in the poorest populations (Nigeria, Bangladesh). Municipal health departments are asking for support and research to understand what works and how they can plan PHC and manage SDOH in rapidly expanding urban centres.

Recommendations: Develop guidance and policies that specifically address the complexities of urban environments to support municipalities to develop PHC systems that meet differing population needs. In conflict and fragile states, learn from best practice examples e.g. Afghanistan. Ensure that PHC plans have policies and procedures that address emergencies related to conflict and environmental changes and those countries with high numbers of refugees work across borders to achieve UHC. Work more closely with communities using participatory action research (PAR) approaches to enhance self-reliance and build assets.

Community Health Workers

Community health systems (CHS) are critical to providing UHC, particularly in rural areas and for marginalised communities. Linked to the Alma Ata declaration with a focus on services where people live, CHS rather than PHC dominated many of the conference sessions. Whilst CHS are in many contexts strengthening, albeit with the support of donors, they remain scarce in urban areas. Re-orientation of health systems to the primary or community level raises many challenges, including fiscal and human resources, population health needs and expectations, planning and contracting services. Community health workers (CHWs) are being presented as the answer to delivering UHC at the primary care level, often with limited discussions about their wellbeing and development. Many CHWs and particularly females are often volunteers working in their own communities and the notion of “exploitation” was raised in many sessions. In addition, there are often tensions between their role as community mobilizers on the one hand and service providers on the other. Hospital and clinical centrism is still a problem for reorienting health systems with too much focus on medical interventions and acting as first responders leaves little time to work on other SDOH and health improvement/community development.

CHWs often work in challenging environments, whether geographical or in conflict and fragile states. Additionally, they experience tension and a mismatch of needs, demands and expectations from the health system, donors, and community. A core aim of CHWs as envisaged at Alma Ata was community mobilisation, which might be in conflict with delivering donor driven services. Many speakers raised concerns over overburdening CHWs and called for improved resourcing and compensation for the work they do. Also, that there should be a move away from volunteerism, which will not improve quality or accountability. Finally, it is important that CHWs not only receive training and supervision but also have the option of progression and a career pathway like any other health worker.

Recommendations: Support, value and reward CHWs as a core element of PHC. Reward does not necessarily have to be financial; training, opportunities for progression and ensuring support is important for motivation and retention. Develop strong CHW programmes in urban areas.

Data, Monitoring and Evaluation

Many countries are in the process of developing or revising indicators to measure the progression of PHC. When considering what to measure, there is a reported need to look at process, what matters to communities and quality rather than just the inputs, outputs, outcomes and impact. Institutionalised use of data to influence programming and improve health outcomes was reported as key to planning PHC and advocating for UHC. Ensuring that a functioning integrated or inter-operable information management system is in place is necessary for planning and prioritising services and programmes. Indicators were described as a useful tool to identify issues that need addressing and to advocate for policy change. The importance of sharing draft indicators with those who will be monitored and those who will be doing the monitoring was raised as a key action. Better understanding and interpretation of data collection at the central level by empowering and improving capacity to read and analyse the data is required in many LMIC settings.

There are a number of tools and indicators used to measure progress; however, interviewees expressed the complexity of trying to incorporate indicators from a range of sources. Having too many indicators leads to lengthy and complex data collection that was a reported challenge. In South Africa, they had a data entry officer, which took the burden away from PHC members. In addition to having indicators and measures, additional monitoring and evaluation to inform service performance and quality needs included; socioeconomic information, accessibility, distance to service provider, service coverage data and capability of the population to go to the health service. Monitoring and evaluation approaches are summarised in a table presented in the main document.

Recommendations: Ensure all countries are in a position to collect, analyse and interpret meaningful data to enhance PHC provision and performance in localities/communities as a priority. Global indicator demands, whilst important, should not drive local data collection.

Private Sector

Increasing private sector (for profit) provision is prolific across many south Asian countries and growing in a number of Sub-Saharan African (SSA) countries. Generally, it was perceived that the private sector can facilitate much needed innovation in the provision of PHC services and in data collection and analysis, however most public-private partnerships (PPPs) are focused on secondary and tertiary provision rather than PHC. A number of key concerns were raised in relation to the private for-profit sector, but most focus was on the limited capacity of governments to contract, purchase, regulate and manage services from the private sector. This includes the regulation of medicines, training, treatments and practice. All health service providers must be accountable to citizens and regulated.

Discussions also focused on the lack of inclusion and communication with smaller private providers of PHC, such as local pharmacies or 'drug shops' who are being left behind in health systems reforms even though they are a key link with communities. The lack of PHC or community health systems in urban areas leave populations with little choice but to use whatever service they can afford. It is also an important reminder that health service users are imperfect consumers and do not always know what they need and if what they are given will address those needs.

The private sector, not for profit, included multiple discussions on a range of actors and organisations from large foundations and organisations, to faith-based organisations (FBO) and local NGOs. Whilst larger organisations focus more on funding and training schemes, many countries in SSA for example are increasingly dependent on FBOs to deliver community interventions. Donors will remain important contributors to health care budgets and plugging gaps, however, many presentations and interviews expressed concerns and uncertainty of how to transition out of donor dependency.

Recommendations: Develop initiatives to better engage, train and support small private providers such as community pharmacists to broaden their role and regulate their prescribing is one way of developing safer PHC services in many urban and rural contexts. Urgent policy level exploration is required for recognizing and strengthening public-private links to achieve comprehensive PHC and UHC. Develop clear mechanisms and legal frameworks for strategic purchasing and regulation and consider the power of purchasing medicines and supplies across countries within geographic regions.

Introduction and Methodology

Health Systems Global, with the support from the Bill & Melinda Gates Foundation (BMGF) commissioned this report to capture discussions around Primary Health Care (PHC) and the private sector during the fifth Global Symposia on Health Systems Research, which took place during October 8-12th, 2018 in Liverpool. The Public Health Institute (LJMU) in partnership with an external consultant undertook the research, which involved recruiting and managing 26 Rapporteurs to capture meaningful data from the sessions and discussions. The conference had over 2368 delegates from 146 countries including scholars, practitioners, funders, policy makers, community activists and the media. 125 parallel sessions and 49 satellite sessions that ran over the 5 days including oral presentations, 451 posters and Thematic Working Group special sessions. Over half of the attendees were from low and middle-income settings, and representative of all regions of the world.

(<http://healthsystemsresearch.org/hsr2018/wp-content/uploads/2018/10/Liverpool-Statement-HSR2018.pdf>)

Data was collected by two methods: 'in session data capture' at the conference and semi-structured interviews with key stakeholders. 26 conference rapporteurs captured 93 sessions and 21 interviews were conducted with policy makers, practitioners, implementers from the public and private sector.

To capture the discussions for both PHC and the private sector, a Data Capture Framework (appendix 1) was used which was developed from the Primary Health Care Performance Initiative (PHCPI) framework (Bitton et al., 2017, Kress et al., 2016, Primary Health Care Performance Initiative, 2017) with elements from the 'Sustainability for innovation framework' developed by Fox et al. (2015). The PHCPI framework encompasses an exploration of the relationship between key financing, workforce and supply inputs, and core PHC functions of first-contact accessibility, comprehensiveness, coordination, continuity, and person-centeredness (Primary Health Care Performance Initiative, 2017). The 25 vital signs were embedded within the Data Capture Framework with specific focus on service delivery elements (C1-C5). The Sustainability for Innovation Framework added an extra dimension to assess how PHC and private sector interventions, programmes, donors and partners consider sustainability across five relational factors; political, organisational, workforce, innovation and financial (Fox et al., 2015). This added dimension helped to capture contextual information related to the presentations to assess for balance and/or challenges of comparability across countries as well as at local, national and subnational levels. In addition, the framework had specific questions embedded to capture elements related to the private sector, including citizen demand for private health care, private health care performance, the outcomes of regulatory interventions and the political economy of pluralistic health systems. To ensure alignment with HSG aims and activities, a glossary, which summarised key concepts and debates relating to; the SDGs, UHC, private health care provision and PHC, was provided to support learning.

Ethical clearance was obtained from the Liverpool John Moores University Ethics Committee. Interviewees were selected either during the conference using the event application or through networking opportunities. Sessions to attend were identified by team leads and allocated to rapporteurs prior to the conference so that could familiarise themselves with the abstracts. A database was shared with all rapporteurs, so they could confirm which sessions to attend and if it clashed with a session of their interest, they could change with another rapporteur. This was to ensure that they could gain as much knowledge and experience as possible to enable a learning and development opportunity.

The rapporteurs completed four days of training one week prior to the conference that involved watching presentations about PHC and the private sector from a variety of sources online and applying the data capture framework. The practice sessions were reviewed by peers and by team leads to improve accuracy of information and understanding of where information should be captured. During the conference, three team leaders met with their group of rapporteurs daily to address any questions

and offer advice. In addition, a 'what's app' group with all rapporteurs was available for timely feedback and communication. Some rapporteurs chose to work in pairs to assure they were capturing as much detail as possible. All sessions were audio recorded and used to fill in additional information into the data capture frameworks after the conference. Some Rapporteurs also took photographs of presentations to aid understanding. In addition, most rapporteurs tweeted about sessions that they were observing to raise the profile of the sessions using #LJMURAPS as well as relevant hashtags such as #HSR2018 AND #UHC2030. A debriefing session followed the conference to identify feedback on the methods and key reflections, which, then fed into the analysis phase.

The analysis process used the framework approach (Gale et al., 2013). The research theme leads familiarised themselves with the data collected by rapporteurs, produced a coding framework and used Nvivo 11 software to categorise and code. The results were charted, synthesised and organised around bold themes and subthemes, presented below.

Findings

How to Achieve Comprehensive Primary Health Care (PHC) and Universal Health Coverage?

PHC is viewed as the main method to achieve Universal Health Coverage (UHC). Core discussions focused on what should be included and considered when developing PHC models and how services can be linked or integrated to tackle the social determinants of Health (SDOH), particularly risks related to Non-Communicable Diseases (NCDs). There are huge differences in PHC systems, which range from well-established systems in China and Thailand, to struggling to take-off systems in conflict and fragile states like Somalia and South Sudan.

The main challenges reported were the lack of a clear PHC service definition, no standard instrument for PHC planning, no clear set of indicators and a lack of capacity within LMICs to perform cost effective analysis. Countries need to decide where best to invest and are using a variety of mechanisms to decide this. They are thinking about different models to deliver PHC rather than tertiary or vertical disease specific platforms of the past. For example, diagonal approaches to conditions such as cardiovascular disease. In some settings, PHC departments within Ministries of Health (MOH) previously existed but were dismantled and need to be, or are being, revived.

Throughout the conference, there was evidence that health systems' thinking is really progressing:

I think the main achievement in the last year is that people, they start thinking about the health system in general. Because before, they thought it's all about the inputs ... But no one tried to think about how to measure the performance of the health system with the country, how to evaluate the performance and to improve it. But fortunately, now they start thinking about that. And they start thinking about the public private, how can we build up a partnership.... the system used to be impact oriented, so they talked about big hospitals, too many beds, CT scans, MRIs, too many primary care centres, but nobody is taking care of the access to quality, the coverage, the satisfaction of the citizens, the cost effectiveness of the system (Director General of PHC, post-conflict setting).

The discussions revealed that the Millennium Development Goals (MDGs) provided a platform to build on; however, they focused on vertical programmes like maternal and child health (MCH) and communicable diseases e.g. HIV/AIDS. SDG 3: 'Ensure healthy lives and promote wellbeing for all at all ages', enables a focus on health system development and UHC. Comprehensive PHC could help achieve crosscutting goals and targets like improved nutrition and prevention of NCDs for example. In the Philippines, the central national agency looked at translating MDG to SDG indicators and

developed a website and monitoring role for subnational adaptation. This included using civil society organisations in regions where they already had MDG scorecards or roadmaps that can be transitioned to the SDGs.

Many presentations and interviews confirmed that on-going verticalisation of health programmes and initiatives, however, is still restricting the ability of governments to deliver a PHC system that is aligned to the Alma-Ata vision. In several presentations and interviews, policy makers expressed concerns related to the integration of communicable and NCDs within a verticalized PHC system:

'Over the last 25 years in South Africa health workers have also been thoroughly trained in HIV. However, no one has done this with NCDs such as diabetes and hypertension. There is a want for integration, but many do not know how to carry it out' (Data capture).

Policy makers showed an understanding of the need for policy reforms towards comprehensive PHC and away from verticalized delivery of health care but direction of how best to do this is lacking:

... We now have to divide medical resources to see how much can go to the NCDs and how much can go to the communicable disease. And I think that is a key challenge we have now because even with the little resources we have, we now have to tackle these very two big, broad areas that are affecting us in the country (PHC researcher from an East African University).

Political Advocacy for Comprehensive PHC

There is still a political bias towards biomedicine and delivering clinical services based in hospitals in which health sector leaders and implementers of PHC are continuously battling against. Whilst there is a global understanding of the need for comprehensive PHC, directors and leaders within government health departments have to present a strong case for PHC to other politicians and ministers:

Now the minister...is very much hospital-centred, yes. But the thing is that we managed to make him understand that if we don't have a good primary healthcare system, the hospital will collapse, any hospital (Director of the Health Department of the Municipal Government, South America).

Political advocacy through communicating information and evidence in the form of a business case was promoted as a good way to drive priority setting and PHC reforms. In addition, learning and models can be presented and utilised from other countries, but context must also be considered as noted by both presenters and interviewees:

'Need to advocate for politicians to take on health as their platform. It is a good vote winner. But need to make the issues understandable to politicians at all levels (Data Capture).'

... You have to prove that you are right, they [policy makers]need to present your case as a business case or as a showcase, you have to present some successful models... We are trying to learn from other countries, of course, but you know every country has got their own special context and values and principles and circumstances. You cannot copy across any model. (Director General of Health, post-conflict, North African setting).

The case study below from a data capture session represents an important message to policy makers. People understand sickness, medicine, hospitals and doctors. They struggle to see the relevance of prevention and health protection measures. Public health approaches were always critical to the Alma Ata vision and need to be embraced if there is going to be any impact on disease reduction.

Kenya Case Study: A representative from the Policy and Strategy Unit in the presidential unit in Kenya summarised their experience. Kenya is not starting from scratch. Kenya has had a hospital health insurance system in place for the past 50 years, so there is a historical commitment, and it is considered part of being a Kenyan. However, the challenge is that it is focused on curative services rather than PHC. There is a strong publicly democratic culture and the public will make noise about everything including benefits that are removed or changed. Therefore, if they receive benefits for hospital care then you cannot throw it out because this is the main draw to take health insurance, and that trust cannot be jeopardised. The push to UHC is very political in Kenya, technical people need to be political or see how to incentivise insurance change. It is difficult for the MOH to make their case for PHC, even if UHC has been agreed in terms of reference; the broader political bodies have yet to understand it. They want to know what was offered before and what they want to offer now from a cost-benefit perspective. Patients are aware of health systems and health insurance but it's not UHC orientated about advocating for this change. Questions are still ongoing; how do you balance political needs and public demands and needs?

Planning and Prioritisation Models

Policy makers spoke about the importance of using data collected at all levels of the health system to guide planning and prioritisation. However, there are multiple challenges in collecting good quality accurate data in LMICs and many gaps exist (more discussed in the data section below). The presentations highlighted the importance of communicating data to policy makers to inform planning and development of PHC systems. Research, monitoring and evaluation are needed for advocacy and assessment of context to understand the magnitude of a problem and translate this to policy makers and key stakeholders. There was a call for more synergies across programmes regarding data collection with fewer, better measures that are people centred and included patient experience, confidence and competency of care.

A Director General of PHC from a post-conflict setting explained that many policymakers, researchers and implementers have attended various universities globally bringing different ideas and models of planning and prioritisation, which need to be considered and adapted:

... because in [post-conflict setting] now, we have got different people are coming from different schools. Some of them have got Masters or PhD from UK, Germany, United States, Canada, Australia, so they're coming from different health systems, different schools, tax-based insurance, private, public, you know, different schools with different primary care and secondary care. So, everyone just thinks that his idea is right. So, you have to bring all of that together and think what is the most convenient for the country. But I think, at the end of the day, we will start with something and we will try to implement it, and then we can adapt according to our context. You don't have to stick to one model or another (Director General of Health, post-conflict, North African setting).

Guatemala are in the process of establishing an integrated health service delivery strategy. They chose to undertake a situational analysis first, then establish what would be the ideal strategy and define a new strategy with indicators based on that information. However, cost effectiveness was not embedded in this process. This is then taken a step further within municipalities who are developing

strategies to achieve UHC using the Urban Health Equity Assessment and Response Tool (Urban HEART) (see WHO, 2016). Other interactive visualisation tools were also proposed such as the Urban Health Atlas (UHA) (<http://urbanhealthatlas.com>), developed and used in Bangladesh to map health care providers in major cities. Its use aims to enhance knowledge of service provision and aid equity in service planning and decision-making.

In South Sudan and Madagascar, the Community Health Planning and Costing Tool (<https://www.msh.org/resources/community-health-planning-and-costing-tool>) was used to support the planning and costing of effective community health services (CHS) packages. The process involved collecting service data through field visits to facilities and district level health departments as well as advice from expert panels with experience of delivering the services. However, they reported a lot of missing data, for example, what type of CHW exists, what are their functions? Do they visit all households or just for those that fall ill?

The Primary Health Care Performance Initiative Framework (PHCPI) (Primary Health Care Performance Initiative, 2017) is being trialled as a tool to help policy makers plan and monitor PHC in several countries including Malaysia and Senegal. Policy makers using the tool found it was a good mechanism for communicating evidence and that it was a strong advocacy tool with measurable outcomes to demonstrate change and make the case for sustainable investment.

Community participation in priority setting for health services has gained importance globally, particularly in resource-poor settings. It is a major principle of people centred health systems, highlighting the intrinsic value and strategic importance of assessing community needs and assets. In addition, the incorporation of community views into priority setting is perceived to restore trust and improve accountability within health care service delivery. In Guatemala, communities were asked to identify priorities, and interestingly they were more clearly linked to the SDOH than to health service delivery. In addition, taking political leaders to the field and showing them the reality was viewed as more effective in communicating planning needs rather than just sharing the latest Lancet evidence.

Decentralisation and Devolution

Decentralisation/devolution of health planning and decision-making is an important element of governance and enhancing accountability. Whilst overarching health policy ambitions should be developed nationally, local adaptability, planning and addressing community needs is critical. This requires leadership and managerial skills at district as well as national level:

'In Kenya the constitution demands transparent, accountable and inclusive governance, making citizen participation a key principle, particularly at county level. However, opportunities for communities to make their needs visible and hold service providers and duty bearers to account are limited, particularly among the most vulnerable groups' (Data capture).

Thailand Case Study: The SDGs have been incorporated into the national reform agenda and 20-year strategic plan. Other plans cascade down from this level. There is a strong commitment from the Prime Minister to society to drive the SDG agenda throughout the country. Thailand has a track record of following international frameworks, for example comprehensive PHC. They also have an embedded structure that includes management and engaging with the community. The SDGs provide a broad health and wellbeing conceptualisation, which aligns to the Thai concept of health as a physical, mental, social and spiritual entity. The SDGs agenda provides health departments a wider remit to work with other sectors. In addition, the government realise that in order to achieve SDGs, the community and local level are crucial in the role to develop self-reliance and care, as the government cannot fund everything. SDGs led to agencies involvement in a wider range of issues e.g. UNICEF now involved in air pollution, disability, UHC, benefits packages. There is an awareness of the political challenges required to address many of the SDG goals. The commercial determinants of health and vested interests e.g. tobacco industry increase the complexity of making laws and policies to protect health.

Decentralisation of health planning is not without challenges and includes inadequate state and district-level architecture, lack of standardisation, financial control constraints and management capacity (e.g. PERFORM project in Uganda). Governments need to consider the geographical constraints in developing national policy, which do not fit with the reality of local resources and capacity to improve health. A novel catchment area technique (Uganda) was developed to provide accessible tools for health facility managers to estimate catchment area size and improve target setting, performance monitoring and improvement.

Mechanisms needed to increase funding streams and autonomy in decision making to districts was a common theme. There is also a need for good local level data to enable PHC decisions. Centralised targets may not be relevant to the local context so there is a need to localise indicators. Devolution of health planning is clearly more difficult for countries with high levels of donor dependency. For example, in Kenya and Malawi, the development of government health programmes is shaped by donor interest and funding which often means that NCDs for example, get less finances.

Integrating NCDs

The integration multiple interventions and programmes into PHC was discussed across many presentations. However, there are challenges, for example, health systems financing was reported as an obstacle to integrating NCDs into PHC, as finances for services remain donor driven and provided for specific vertical programmes like HIV/AIDS and Tuberculosis (TB). As such, whilst the will for integration is there, the skills and resources are not. However, an interviewee from Southeast Africa stated that international aid is becoming more flexible towards supporting health system development and recognising the need to move away from vertical funding streams that restrict this:

So, there's really conscious bias towards moving, not just the focus, but even the resources towards community health system. So, when you look at our major grants, like the [donor] grant, there's so much that's going towards the community level, strengthening the community level system. ...for the grant that's running from 2018, [donor], to 2020, there was realisation even from the [donor] side that, you know, we can't just go on like funding TB, HIV, malaria, because there are [health] systems that need addressing. And actually, the systems that are created for prevention are really at the community level (Deputy Director of Planning in the Ministry of Health and Population, Southeast Africa).

When asked why there has been a change in donor views, the interviewee explained that there was under spending and that weak health systems cannot meet targets:

There's an issue of low absorption of [donor] Fund resources and across so many countries. The main contributing factor of that is you have systems that are really not properly functional, you have very few health workers, for example, you don't have equipment. So I think they realise that even if you want to deliver malaria, there's no system there, so how are we going to deliver this (Deputy Director of Planning in the Ministry of Health and Population, Southeast Africa).

Issues related to tackling NCDs included being able to provide screening that links to a continuation of care, which was reported as a gap within government planning. In addition, sufficient training is lacking for NCDs and presenters suggested that the current training curriculum for health workers needs revision to understand the gaps and requirements to increase capacity of health workers to prevent, treat and manage NCDs. In a Southeast African country, the health system is taking a different approach to integrating prevention for NCDs by supporting existing CHWs to re-focus on SDOH and employing extension workers outside of the health sector. CHWs when first developed did focus on SDOH but during the MDGs, they became directed towards providing services for programmes like MCH, malaria, TB and HIV/AIDS:

I think the thinking initially was just focusing on ourselves [the health sector] pretty much. So I think everybody's realising that and thinking, okay, can we really work more with other sectors, that really determine health more than we do ourselves in the health sector (Deputy Director of Planning in the Ministry of Health and Population, Southeast Africa).

In addition, a review of District Health Information System (DHIS-2) in sixty LMICs presented an opportunity to exchange and integrate data from different sources and conduct analyses that could facilitate multi-sectoral actions. However, they found that DHIS-2 was largely used for disease surveillance and service utilization data rather than for guidance when making decisions.

One presentation discussed a method to monitor the level of service integration within health systems. They used Principal Components Analysis to develop facility-level integration indexes to reflect provider (Provider Integration Index) and facility (Physical Integration Index) capacity to offer integrated services. The range of scores within the study demonstrated that measuring integration as continuous rather than binary may enable a more accurate reflection of integration variation within and across health facilities. This would further enable nuanced measurement of integration determinants and effects and provide tailored information about how best to support providers and facilities to improve integration.

Changing and Emerging Context matters, But What Does This mean for PHC and UHC?

Fragile and Conflict Affected states

The impact of conflict, protracted conflict and fragile states on establishing PHC and reaching UHC cut across several presentations and group discussions. Fragile states are increasing, with approximately 60% of people from LMICs living in fragile states that are disruptive and have complex consequences on health systems. War results in injuries, delayed medical supplies, displacement, self-medication and psychological trauma, which are then transferred to neighbouring countries and communities as refugees' flee to safe areas. In addition, attacks on health infrastructure and staff, including CHWs pose additional risks.

Conflict affected states (e.g. Syria) mean that hundreds of thousands of people flee to neighbouring countries (Lebanon, Jordan, Turkey) with physical and mental health challenges including overcrowding in temporary shelters, high risk of disease outbreaks and stress in surrounding communities.

Refugees from Syria often present with PTSD alongside NCDs such as hypertension and diabetes. Health facilities at borders are not able to meet refugee needs due to limited human resources, stigma, fear and a lack of mental health awareness and skills. In Jordan, an NCD awareness training intervention is providing health education to address behaviour change and mental health issues. In countries greatly affected by refugees such as Lebanon and Liberia there is a need for regular population needs assessments and adjustments. Health service provision in conflict and protracted conflict settings are often delivered by NGOs, faith based and humanitarian organisations with some support from the host government. Lebanon is the largest refugee hosting country worldwide in relation to its population size and the refugee influx has had substantial impact on the PHC system, which has stretched resources. One issue raised was the tensions between the refugees and the local host population who feel they are receiving less provision (and they probably are) (examples cited Uganda and Lebanon).

In areas with protracted conflict and on-going fragility, health systems are disrupted and fragmented for example in Somalia and South Sudan. Over 20 years of armed conflict in one district of Uganda resulted in a marked disruption of the health system including; ineffective functionality of leadership and governance structures at community, health facility and district levels hindering the ability to monitor health services; challenges in attracting and retaining health workers partly due to poor infrastructure, insufficient equipment, inadequate social amenities and poor pay resulting in poor health worker-population ratio compared to other regions of the country. Quality care is often compromised in these settings. In protracted crisis settings such as South Sudan efforts to plan community health services within a 'broken health system' struggle to get a budget for PHC.

One interviewee from a post-conflict setting described the financial and human resource challenges of building the health system in periods of instability:

..the system used to be depending on individuals...so all those individuals, either they have been killed during the revolution or they escaped away and they are living in other countries, so the system collapsed...And when the system collapse, you know, some people they will try to use it for their own interest and the resources become quite limited, because most of the money of the country is outside the country. And most of those bank accounts are frozen now because of security and instability, and leaders, national or international leaders, they are afraid that that money would be used in illegal ways or with terrorists, et cetera...so we have to think how to make our health system effective (Director General of Health, post-conflict, North African setting).

There were good examples of improvements in health service coverage in a fragile state context despite economic and political-military shocks. In 2002, the MOH Afghanistan with the support of the international community adopted the contracted-out mechanism and developed the Basic Package of Health Services (BPHS) (PHC focused) and an Essential Package of Hospital Services (EPHS). They also decided to contract NGOs, as the MOH lacked capacity to rapidly expand the services. Other interventions in protracted conflict settings include psychosocial support training for health workers, redistribution of medical stock and adjustment of reimbursement to reduce financial burden on refugees. Questions were raised on how refugee health workers could be better utilised to support the health of their fellow refugees and how could this be formalised within a system that does not recognise their qualifications (example Lebanon).

Reliable and current data on how fragile and conflict-affected states have progressed towards achieving health-related targets is needed; data from insecure nations however is often scarce. Governments in fragile states have to consider transition arrangements when donor dependency is a key feature of the health system. Though this works both ways, whereby donors need to consider exit strategies, which offer some kind of sustainability.

In countries coming out of conflict there is a belief that there is a window of opportunity to influence political opinion, leadership and a focus for PHC. However, one interviewee described the difficulty of establishing a more democratic way of working following a long dictatorship:

I will control the output at the end of the day, because you cannot give it to them [government bodies] because they will not reach an agreement. You know, because when you live for 42 years of dictatorship with just one idea and one teller and one direction, it's quite difficult to have, all of a sudden, this space of freedom and democracy, it becomes chaos (Programme Director, Ministry of Health, post conflict, West Africa context).

Urbanisation

Rapid unplanned urbanisation has raised the need for a better understanding of how to manage the complex determinants of health and provide affordable and accessible PHC in cities. For example, in Bangladesh it is estimated that by 2050 approximately 60% of the population will live in urban areas. Urbanisation brings new health problems that need addressing:

I think this [urbanisation] is going to become a real problem for the country in ten years from now, because it's already happening very much... when you start to have more and more people in the same area, and having such a connection as with the one we have with the United States, that there is a lot of gangs and narco traffic going on. Plus, violence is an important problem in our cities (Director of the Health Department of the Municipal Government, South America).

The presentations and interviews raised issues related to delivering PHC and tackling the SDOH such as health education, sanitation, clean water and nutrition within diverse urban populations with varying cultures and needs. Research and interventions have tended to focus more on rural settings, leaving a gap in knowledge related to delivering PHC in urban areas. There is a suggestion that rural populations are easier to manage due to their homogeneity, established community structures and hierarchies. Conversely, in urban settings populations are more diverse, with multiple uncoordinated and unregulated structures and a range of profit and not for profit private sector providers. This is increasing health inequities in urban areas especially among informal urban settlements i.e. slums and squatter camps (e.g. in Nigeria, Bangladesh, Kenya, India, Guatemala):

I think urbanisation is... it has implications for the way we deliver care. So, an example is, in the city where I live...there was a cholera outbreak, I think it was two years ago. So, you have like an increase in the slums ... people who are living in the slums and the urban area, you know, are actually worse off than people in the rural areas... the water supply in that area isn't properly organised, the housing is so congested, things can easily, you know, like be transmitted. So there are really important implications for not just us as health sector but how we work with other sectors to address the issue of urbanisation and health, yeah (Deputy Director of Planning in the Ministry of Health and Population).

In some cities, municipal governments have independent health departments that require adaptable health policies to meet the needs of urban populations with complex health issues. In some cases, municipal governments are not well linked with the MOH and lack direction. There is a need to strengthen the managerial capacity of these departments given their close proximity to local population health needs. The interviews demonstrated how higher education (Masters or PhDs) provided municipal leaders with tools to manage health departments. One interviewee described:

...while I was doing my Master of Public Health, I identify other tools that were useful to try to engage to the different decision-makers and understand better the power dynamics... Because there was some rejection by the Ministry of Health with actions that the municipality had taken since 2012. And since then, we managed to move from being kind of separated into establishing

what would be the first integrated health service delivery network (Director of the Health Department of the Municipal Government, South America).

In Bangladesh, the Urban Primary Health Care Services Delivery Project (UPHSDP) together with the decentralized health system authority is working to increase capacity to manage contracts and purchase health services more effectively and to improve the health status of the urban poor, especially women and children with a focus on access to PHC. Building the capacity of local governments to manage, finance, plan, evaluate and coordinate health services is a main priority (<https://healthmarketinnovations.org/program/bangladesh-urban-primary-health-care-services-delivery-project>).

In India, there are private sector entrepreneurs who are providing some form of primary care in urban areas using technology to improve cost efficiencies, though these schemes tend to be very biomedical and treatment oriented. MHealth and EHealth are regarded as cost-effective and innovative methods of providing health care, which may be true, but as one plenary speaker exclaimed with reference to innovations and gizmos, *'what of toilets'*. Expressing a sentiment felt by many at the conference. The SDOH are broad but fit well with the SDGs and through a refocused PHC and public health approach should be a critical element of UHC.

Guatemala Case Study: In Guatemala, advocacy has supported the development of active channels of communication in all 35 municipalities to discuss problems and solutions, in addition 28 municipalities are allocating finances to improve service delivery and tackle inequities. Findings suggest reduced discrimination and better responsiveness of providers and local authorities who are working with indigenous citizens to demand changes higher up at the provincial and national level, as many problems are not under the control of local authority but more systemic. Community clinics were established to deliver PHC services, however coordination between services was a problem. A health commission was set up with stakeholders, including community leaders, to identify priorities and as a result, a Memorandum of Understanding was developed with the MOH.

The presentations highlighted a need for better forward planning for UHC in areas that are undergoing rapid urbanisation. Presenters and interviewees raised the importance of having health service providers working together and the challenges related to pluralistic health providers.

Governance, Leadership and Accountability

This was a very strong theme running through many sessions and without it many interventions and strategies are failing to achieve their optimum outcomes.

Strong Leadership and Commitment

In most global strategies, there is an emphasis on governments taking a leadership role in protecting and promoting the health of their populations. Governments taking ownership of UHC is critical to its realisation as noted by an interviewee in a West African post-conflict setting:

I think that can just basically be addressed when government take ownership. Ownership not just for the sake of saying we take ownership in terms of just the human resource, but also the capital investment into ensuring that you sustain or maintain the resources you have (Programme Director, Ministry of Health, post conflict, West Africa context).

A number of speakers referred to the need for a 'revitalisation and reorientation' of a PHC focus following the SDGs (particularly in goal 3.8: UHC) which requires 'strong leadership and political agreement'. Ideally, this would go beyond a ruling party agreement to a whole- system agreement

across parties and institutions. An example of this is Peru where health reform measures were introduced by the ruling political party but gained a cross-party approval of a Universal Health Insurance scheme. Initially based on pilot schemes, it has now scaled up and expanded for full population coverage. In 2017, India's National Health Plan outlined plans for a progressive achievement of Universal Health Care (UHC). Launched in 2018 under the banner of 'Modicare' (<https://www.modicare.com/>), this health insurance scheme aims to reach > 500, million people living in poverty.

Historical PHC systems still exist; many have not evolved with emerging health needs, thus the need for on-going discussions of how to overcome the challenges of building on existing systems:

'There is a need to understand continuous negotiation, need to understand leadership competency and good negotiation skills, to influence policy and how to engage public and private sector together' (Data capture).

The importance of strong leadership and management competencies in building resilient and responsive health systems in LMICs is recognised, particularly in SSA. Effective healthcare leadership is required when engaging with other stakeholders in moving towards UHC in LMICs. Challenges and concerns in the leadership of developing comprehensive PHC systems remain with respect to purchasing processes, private sector involvement, NCDs and social determinants of health. Also, how to work across ministries and sectors – for example, Ministry of Finance and Transport:

'The MOH is no longer the only provider and purchaser, but one of the several governance actors in the context of multiple purchasers and providers of health care. Improving health systems (HS) requires strong leadership and coordinated actions between parties including: health, finance and other non-health sectors; governmental, nongovernmental, bilateral and multilateral agencies; policy makers, managers and providers; and researchers and users (Data capture).

Highly centralised governments such as China have a long history of health system governance characterized by centralised political commitments, combined with a hierarchical administrative system, and national guidelines. However, China is challenged like all countries with an ageing population, increasing NCDs and the lack of quality data systems in many regions. Many countries do not have the same capacity to follow China's commitment, however, with improvements in leadership and analytical skills there are opportunities to engage public and private providers across sectors to reach health goals using consultation, collaboration and negotiation skills.

A key concern across many areas is how to sustain health initiatives when donor funding ends and how to promote capacity building in leadership, decision-making and accountability, in other words, the institutionalisation of health governance. Delegates discussed the need for better integration between researchers, practitioners and policy makers like the National Institute for Clinical Excellence (NICE) in the UK, at higher levels and at lower levels so that professionals act in a consistent way. This means that no one body is making a decision, it takes courage for policy makers to make difficult decisions and the process of decision making needs to be transparent and shared to protect them from public challenges. An inclusive process that is also transparent will help quality and decision-making that stands up with a clear evidence track. It can show the public which decisions will have reasonable impact on population health and why they were made.

Accountability, Transparency and Responsiveness of PHC systems

Accountability was raised in a number of sessions with questions about who is accountable for decision-making, resource allocation and the development and provision of quality health care. Donors or government agencies, national or local? In addition, are they accountable to citizens and local populations?

The conference provided a number of methods to increase accountability to communities. These included; engaging civil society, community scorecards, health facility and district level councils and committees and through CHWs' (historical accountability of barefoot doctors in China). Other public engagement tools included using the media, radio, surveys and interviews following service experiences, photos, exhibitions, and a community assembly for complaints with a health professional present. It was noted that citizen participation (Kenya, Ghana, Ethiopia, Tanzania) in priority setting and holding services accountable by those who receive them is challenging because of a lack of capacity and opportunity to voice their needs, especially with vulnerable populations. Kenya provided examples of Council Health Service Boards and Health Facility Governing Committees. In addition, the use of participatory action research (PAR) cycles and participatory planning processes to improve quality and promote joint solution finding was used in a number of countries, including Cameroon, Nigeria and Uganda. It should be noted that generally, communities do not have the capacity to compare prices or always have the ability to assess the quality of services and products. This implies the need for regulation throughout the health system, in particular the *'Accreditation of facilities is necessary for regulation and accountability' (Data Capture)*.

Collaborations and Multisectoral Working

Multi-sectoral collaboration and partnerships between actors/agencies including: health, finance and other non-health sectors; governmental, non-governmental organisations (NGOs), bilateral and multilateral agencies; policy makers, managers and providers; and researchers and users is viewed as essential to UHC. However, it was noted that it is important to identify clear roles and leadership in partnerships and collaboration. It is expected that the MOH assume the leadership role, with technical and financial support from the international community and implementing partners for supporting training, supervision and monitoring. It was noted by one speaker however, that *'Donors have the power and control everything and this leaves the host nations powerless to speak up against some issues they do not agree with' (Data capture)*. Some key features of good partnership working were noted including; trusting relationships, pooled procurement and funding, adopting broad and shared frameworks to ensure a common understanding of technical concepts, build consensus and ensure ownership and long-term political sustainability. In addition, shared goals and outcomes, shared learning to strengthen capacity, identified champions, and having strategic figures at state and national level to drive the partnerships. However, the co-ordination and alignment between and among actors (government at different levels and multiple donors) is certainly no simple task.

Another speaker noted the importance of developing local institutions for gathering, filtering and sharing evidence, locally, nationally and south to south. These institutions can sit outside of the MOH, for example in Thailand there is a public agency (National Health Commission) under the Security Council rather than the Ministry of Health. It has a remit to work across sectors with all relevant departments and levels of government and the private sector. Increasing collaboration and partnership working with organisations, which sit outside the state sector and in this context broadly called the private sector is clearly increasing. In Ghana, for example there have been policies to strengthen the relationship between Faith Based Healthcare Providers (FBHP) and government in the move towards achieving UHC. The private sector is regarded as critical to the realisation of UHC but requires regulation at all levels and needs to be accountable to citizens (see private sector section).

Case Study from India and South Africa: HealthRise started with a needs assessment for hypertension and diabetes prevalence. They looked at rates at district levels and at barriers to care across the continuum from both the patient side (demand) as well as the supply side. It started at the same time as the national guidelines for NCDs were introduced. Epidemiology was telling them that there was a huge burden that needed to be addressed. There was a gap that could be filled by creating partnerships, which included having strategic figures at state and national level to drive partnerships with institutions who had sufficient capacity to deliver and work with the community. HealthRise brought in multiple partners such as ground level institutions and those that could work with health systems to implement the project and work through the challenges. Having officials working at the top and being prepared, meant that the services were able to trickle down through to the patient. There were several policies to be considered: from the CHWs to the adherence guidelines. During initial stages of creation, they worked closely with several stakeholders and created partnerships at different levels. They embedded HealthRise within the national MOH during the creation of the intervention but also for advice. At the provisional level, they set up within district system and the provincial healthcare body. The learning from HIV has taught them a lot about what it takes to get into partnerships with health systems and having strategic figures at state and national level to drive the partnerships was of importance. Health systems and formal institutions should use informal platforms and must come together to achieve and fulfil the demands and needs of the patient.

Scale Up

There were discussions around scaling up interventions and suggestions that this should be a theme for the next conference. Scaling or not scaling up is viewed as the missing link between innovation, solutions and longer-term implementation and sustainability. There is a need to move away from short-term pilot projects and invest in longer-term strategies. Two issues raised with scaling up interventions are a lack of direction and understanding of how to scale up and a lack of initial planning with the view to scale up if successful. Resources are potentially wasted by not building in scale up if programmes show success. There were lots of statements like *'Community midwifery should be introduced and scaled up especially in developing countries which have large populations living in rural areas'* (Data capture); but no indication of how this would be achieved. In addition, a low literacy CHW programme worked well and demonstrated a way to increase UHC and equity but how to scale up is not known; rather it was raised as a further research agenda.

When thinking of scaling up, some critical points were raised in one session. Trying to change behaviour at the micro level is very difficult. Presenters found that when interventions were only applied at this level, it was not enough for sustainability; there must also be structural changes at the level of governance to expand the solution space from micro to structural level. Horizontal and vertical scale up with process evaluation is suggested. Vertical scale up to set up support structures to institutionalise the intervention and ensure inclusion in policy and documents with clear links to key stakeholders is suggested. National scale up steps suggested included developing steering groups to develop a country plan for scale up, adapting it and slowly growing through regions/counties. The Perform2Scale (<http://www.perform2scale.org>) project (Malawi, Uganda and Ghana) included some measures such as; are there champions of the initiative? Is it included in policies and guidelines? Is it part of the usual work? For their programme that looked at strengthening the capacity of district managers, they also measured workforce performance and completed management competency assessments. Scale up lessons shared from South Sudan and Madagascar included frequent interactions with district management teams, holding national workshops with stakeholders and project staff, along with webinars, meetings, workshops, reflections and process evaluation.

Financial Planning and Management

Financing UHC, managing financial resources and sound fiscal management is a critical area of governance at all levels. Yet it was noted in a number of sessions that sound financial planning and fiscal management is absent or weak in health systems at all levels. Governments and development agencies want to know what to spend their money on to support UHC and there is an identified need to share not only experiences but also purchasing across regions for benefit and negotiation power. There are joint challenges, which could be solved with better cross-region collaborations for funding supplies and medicines for example. For this to happen, financing reforms are needed. There are calls for better support for aid coordination and recognition that donor priorities do not always align with country priorities. Questions posed during one session on health financing were:

- How do we design and cost basic health packages?
- Substantial amounts of funding given to governments are earmarked, what do you do when you have a resource envelope that does not work?
- How to get the private sector on board and have good purchasing mechanisms?
- When governments engage the private sector, how do they negotiate prices and manage quality? Price variations between providers is an issue i.e. paracetamol varies hugely with LMICs often paying the most as they do not have negotiating power. Even though most drugs no longer have patents, the costs still vary. The UK and US have cheaper prices; competition for products is not working in LMICs. Some governments pay more than 25 times the price and on average pay 14 times as much as the best performing governments.
- Domestic spending – how can governments and partners de-fragment funding?
- How do we support district budgeting?
- What needs to be in place for a LMIC to realise some of the savings, otherwise they will not manage UHC – what information is needed to negotiate prices and avoid out of pocket spending)?

Suggestions from presenters and the audience to improve funding flows included pooling funds through better-coordinated aid investment, supporting routine performance and financing reforms through strategic purchasing that is demand driven. Also, encouraging Ministries of Health to state where they need support and help for fiscal planning and ensuring that the Ministry of Finance handles the financial side of planning and monitoring with support from the Ministry of Health, not the other way around.

The conference had many discussions that considered ways to build government capacity for strategic purchasing, one definition given was:

‘Strategic purchasing means linking payments to information on provider performance and health needs of the population. Purchasing translates budgeting/funding into benefits and includes payment systems and contracts, integrated information management system, effective governance arrangements which link to UHC intermediate objectives like efficiency, accountability, transparency, and equitable distribution to achieve UHC final goals (fair financing and financial protection, health service quality). Thus, not only more money for health but also more health for the money. There is no progress towards UHC without efficient spending’ (Data capture).

Strategic purchasing was discussed in relation to the private for-profit sector as well as international and national NGOs and for the procurement of medicines and supplies. Strategic purchasing aspects included payment systems and contracts, integrated information management systems, effective governance arrangements which link to UHC intermediate objectives like efficiency, accountability, transparency, and equitable distribution to achieve UHC goals through fair financing and financial

protection, and health service quality. Transparency and timely payments in health systems is paramount.

Effective contracting governance was discussed as a means to; increase health coverage in hard to reach areas, help to deliver services that are under provided, improve the functionality and quality of services and ultimately lower costs. Contracting has been delivered better in some countries than in others and this raises the need to look critically at how contracting with private providers is designed, managed and regulated in LMICs. Stewardship capacity for contracting was reported to be weak, lacking in specialised staff and support systems for writing, pricing and tendering contracts and a lack of understanding of how to undertake fair and responsible contracting agreements. Concerns were raised from providers about timely repayment, low reimbursement rate and rising empanelment standards, which are particularly challenging for facilities/services in resource-deprived areas. Providers were also reported as being unsure as to what can be covered due to unclear policy guidelines/price discrepancies. In some cases, the private sector had lost interest over time due to long tedious tendering processes.

Afghanistan Case Study: Strategic purchasing was supported by a clear understanding in the contract between government and NGOs on expected outcomes of the projects. In addition, strong management capacity of the MoH (central and provisional level), effective human resources and pharmaceutical management were notable elements that contributed to the successful delivery of the basic package of health services.

India Case Study: The Government of India is planning to organize a workshop on strategic purchasing and PPP contract management as part of their national health mission.

In one presentation, a health economist stated that a minimum of \$2.5 billion could be saved across 50 of the poorest countries in the world with improved procurement. Access to affordable medicines is a key part of achieving SDG 3; however, this remains a challenge to millions of citizens. In addition, there was a stated need to strengthen the accessibility of quality medicines through sound procurement systems. Attaining affordable quality products and equipment meant that negotiation skills were needed to get discounts on drugs, consumables and equipment and a pooled procurement inventory management system was suggested as best practice. One suggestion was that regions should work together to agree on purchasing and regulation to gain power and negotiating strength. However, joint procurement is challenging when different countries have different policies and payment structures, for example, some pay in advance, some pay after. However, some EU countries have done this and successfully negotiated better deals.

Financial Risk Protection

To better inform PHC investment needs, it is critical to understand the degree to which gaps in service coverage and financial risk protection remain the primary barriers to achieving UHC. Catastrophic spending because of out of pocket expenditure (OOPE) for health services was raised as a major issue in many presentations, especially within LMICs and for the poorest populations. One presentation looked at tracking service coverage and catastrophic health spending in 188 countries between 1990-2017 and reported:

UHC service coverage improved more quickly than catastrophic health spending, underscoring the need to prioritize policies and resources for financial risk protection in parallel with health service expansion... This study highlights the importance of measuring UHC for all countries over time. To better inform UHC investment needs, it is critical to understand the degree to which gaps in service coverage and financial risk protection remain the primary barriers to achieving

UHC. These results offer decision-makers the evidence base needed to strengthen health systems so that they can truly deliver for all (Data capture).

The presentations that looked at catastrophic spending measured it differently. For example, some defined it as '25% of total household expenditures spent on health using household survey data' whereas others 'as a situation when health care spending goes beyond 40% of capacity to pay' (Data capture). One province in South Africa is aiming to remove OOPE for citizens:

That's just came out to say that the aim of that is to remove out-of-pocket payments. And the aim is that there will be one national fund and that primary care providers must move to a capitation fee, rather than out-of-pocket and fee-for-service (Data Capture).

Health insurance schemes are being presented as the answer to OOPE and catastrophic spending. Health Insurance schemes referred to included:

- Micro health insurance
- Community based health insurance
- Micro lending schemes (both formal and informal)
- Social health insurance schemes run by governments or contracted to private providers

Community and social insurance schemes are seen as important financing methods to promote SDG 3.8 and a number of countries are now committing to developing these programmes such as Kenya. A big question remains 'what's in what's out?' This is true for all countries at different levels of health system development. Countries will be required not only to meet health needs and expectations but also to implement insurance schemes underpinned by sound financial planning and an economic understanding of costs and benefits for numerous treatments and interventions.

However, health insurance schemes were raised as a potential risk for PHC, especially for the poor. In SSA, the piloting of mechanisms to target the poor and achieve coverage are being trialled. However, charging premiums for national health insurance presents barriers to participation for the poor.

So, I think there's still quite a lot of work that can be done if those governments are really serious about reaching the poor. But what they're doing in Kenya now is looking to pilot what they're referring to as universal health coverage initiative in four counties...There are free health services in those countries already through public sector providers, but as more and more of the funding goes through national health insurance, where you're only supposed to pay a premium and if not you get a waiver, then there's issues of how to identify the poor and how to provide those free waivers become more important (International NGO).

There is a highlighted need for pre-payment insurance mechanisms that are equitable, not just for the wealthy. Some transitioning countries from low to middle income have successfully set up pre-payment mechanisms and have put in place plans to offset OOPE spending as donors pull out, but others have not, such as Cambodia. Thailand provides a good case study for social health insurance, the Universal Coverage Scheme (UCS), which has developed over a number of years aims to provide UHC via 3 inter-related dimensions: population coverage, service coverage, and financial protection. The UHC has evolved through five stages of development aimed at increasing coverage and financial protection. This has included development from a compulsory scheme for civil workers and pensioners and a voluntary scheme for others, to a scheme that targets the entire population with 5 sub-groups and 25 different categories. Some LMICs are at the beginning of their journey into health insurance schemes, which include PHC. For example, Nepal who implemented the Social Health Security Programme (Health Insurance) in 2016. Challenges include rolling out to all districts, ensuring the poorest receive subsidised health cards and controlling the prices charged by the private sector.

However, as noted in one presentation: *'In some cases, private provider's participation has led to increased costs for health insurance members' (Data capture).*

Ghana Case Study: Ghana's nationwide health insurance scheme (NHIS) aims to prevent out of pocket user fees at the point of service delivery. Established in 2005 as part of efforts to ensure access to affordable and equitable healthcare. Enrolment on the scheme is mandatory with the formal sector having compulsory deductions at source and informal sector expected to pay via annual premium payments. However, enforcement remains challenging and active enrolment remains low even when it covers most common health conditions. Suggestions that there might be a lack of awareness or understanding of insurance status and what services are covered and which are not – what's in and what's out?

Likewise, in Bangladesh where OOP spending remains extremely high it is estimated that:

'Less than 1% of population covered by any health insurance protection scheme. Micro Health Insurance approaches are being tested in numerous countries including Bangladesh. Uptake is often low which could be due to many reasons but one important one put forward relates to the idea of 'pooling of health risk' (Data Capture).

If the concept of health insurance were not well understood amongst populations, why would they buy in? In India, simple animated videos were developed and shared across media platforms to inform and explain to local populations what social insurance in health is and how they benefit from joining the scheme. Across presentations, factors being associated with higher enrolment on insurance schemes included; higher education attainment, wealthier, having a link with a development NGO, living with a chronic illness or living close to a health facility. Suggested ways to improve enrolment were; designing marketing techniques targeted towards lower literacy groups, matching premium collection time with income flow as many receive fluctuating income flow and premium collection needs to be adaptable for this factor and excluding some pre-existing conditions of potential clients until scheme reaches financial stability. Developing social insurance health schemes will be critical to UHC but more attention is required to educate the population in the 'pooling of health risk'. Partnerships between governments, citizens, civil society and NGOs will be important element of developing national or social insurance schemes.

Currently many insurance schemes focus on secondary and tertiary services and not PHC, particularly in urban areas in India, Pakistan and Bangladesh.

It [insurance model] only focuses on tertiary care, it only focuses on hospitalisation, it's the insurance model. And the insurance model is more exclusionary than inclusive... it doesn't have preventive care, it only takes a few of the diseases recognised by the insurance for treatment (India data capture).

Nepal alongside Indonesia was referred to as 'big bang' with reference to rolling out health insurance programmes for UHC and decentralisation of government functions. These will be interesting countries to watch over the next 10 years.

What is the UHC Price Tag?

A presentation by WHO focused on ways to measure and fund health expenditure in LMICs. What is the SDG price tag is clearly an important question? They argued that 70% of the cost of SDG 3 is at the PHC level. Their aims are to develop a standardised method to track PHC expenditure and provide comparable PHC expenditure estimates and formulate recommendations for future PHC tracking. To map PHC outcomes they used the System of Health Accounts (SHA2011) tool. Measures discussed included: PHC expenditure, PHC % of current health expenditure and government PHC spending as %

of total expenditure. Challenges reported were; variation in country service delivery, no clear PHC definition, no standard instrument for PHC measures and data coming from various sources which made systematic analysis challenging.

Defining PHC and what services should be included or provided remains contested. Two classifications were put forward: the Health Provider and Functional Classification. A **Functional classification** of PHC is defined by the purpose of the activities, which considered individual and collective health care goods and services, basic purposes of care (e.g. curative, rehabilitative, long term care) and modes of provision (e.g. inpatient care, outpatient care). The organisations and actors that deliver health care goods and services, which can be health centre, define the **Health Provider classification**. **Health Provider** includes; outpatient services, medical goods, long-term care and rehabilitative care and maternal delivery, which can be PHC or hospital, based. Complications arise because hospitals are excluded from the examples given but they provide outpatient services, which can be considered as PHC.

The study concluded that PHC costs were between \$20-50 per capita and that most methods of PHC gave similar results, except when there is a change to provider-based classification, you have a lower level of expenditure. The discussion raised some clear challenges to estimating the cost of UHC:

- No clear definition of PHC, varies by countries, large variations in cost because of this
- The existing measure SHA2011 is not sufficient, misses medicines and ancillary services
- Data limitations, many countries do not report on all classifications

Discussion noted that globally we are not ready to measure UHC costs; we need to work on initial measurements, beginning at country level and identify what changes are needed. Measuring patient and private household expenditure is challenging, 'Have you experienced an illness?' and 'Did you visit a provider?' is not enough, we also need to know is it a clinic or hospital visit. These issues arise as surveys are self-reported and language varies at the local level across contexts. In addition, financial protection indicators are weak, and surveys do not happen every year. There is a need for better survey data for OOPE, potentially through an annual survey on household spending. Globally there needs to be an agreement on one measure collectively so we can have some sort of comparison.

Human Resources for Health

Human resources for health remains a challenge and improving the health sector workforce in terms of numbers, accessibility and quality is a key target in SDG 3. Human resource challenges cut across presentations and were often related to discussions about achieving quality health care. Workforce shortages from brain drain to both for-profit and not for profit sectors and migration out of LMICs to higher income countries were reported. Public sector workers sometimes 'retire' early to work in the private sector as reported in India and South Africa because of; better management of staff and higher morale, monthly salaries provided on time, opportunities to learn, and better job satisfaction. This health workforce drain from public services means that there is less time for health workers to spend with patients and more patients to see. This is compounded by late or failure to pay health service providers and limited career progression opportunities. However, this can be contradicted by a study, which presented the motivations of health workers in an attempt to attract them to work in the public sector. The findings identified reasons that attract people to the public sector as more patients and opportunities, stronger sense of contribution to the community and the nation, better equipment or facilities and more training opportunities.

The outcomes of workforce shortages reported within the presentations were; poor attitudes of health staff that result in decreased health seeking behaviour and reliance on traditional healers and persistent absenteeism. Motivation and job satisfaction are important to sustain health workers in

low resource settings where 'burn out' is a common feature. One interviewee from a SSA country was extremely candid and reminds us that;

Nobody's going to sacrifice through all your life working for government or, say, because you love your people. I mean, you love your people, you can work four, five years, but you can't work your whole life because your family have to survive (Programme Director, Ministry of Health, post conflict, West Africa context).

Health workers are often reluctant to work in rural areas and so there is a need for innovations to locally develop the health workforce in these areas. For example; in Nigeria, one intervention engaged local communities in the selection of members interested in becoming community midwives who were then supported by training and enrolling them as government employees. This ensured community midwives returned to their communities to reside in and provide services to upon completion of their studies. In Kenya, an incentive framework was used to support health workers to work in areas that were under-resourced for 3 years and once this was complete, the county would support the health worker through post-graduate or government training. This has helped attract and retain people to work within the county. This strategy is building pace across the country.

The level of human resource gaps is difficult to measure, as there was limited data about the quantity of health workers or where they were at any given time. As a result, facilities could be either over or under staffed. In addition, presenters called for more data regarding the financial resources necessary to incentivize, supervise, and provide logistical support to health workers. In Northern Uganda, computers were provided, and health worker attendance data was inputted into the system for further evaluation. Staff attendance data was submitted monthly together with other health facility reports, and electronically entered in software at district level and analysed. Supportive supervision and feedback was provided to health facilities every three months.

A number of solutions emerged from the conference, which included strengthening staff capacity, leadership and management skills, task shifting, on-going training/Continuing Professional Development (CPD), IT, EHealth and MHealth innovations. Many solutions focused on nurses, midwives and CHWs task shifting. Task shifting to less qualified health personnel is required as doctors are in short supply, particularly in rural areas. Task shifting is a global wide endeavour with programmes aimed at strengthening the capacity and capability of nurses to lead frontline health worker teams. Skills required include decision interpretation, leadership and management competencies, quality and data management. Methods of training could include distance learning, though this would not be easily accessible in rural areas. Learning soft skills such as managing change, building relationships, problem solving and changing to competency-based curriculums where active learning is encouraged, are seen as potential solutions to current challenges in providing quality care.

Another consideration is skilling up CHWs and TBAs for example to provide ANC and skilled birth attendance as well as understand obstetric emergencies.

'An important consideration for UHC is that local health resources such as TBAs, especially in remote and underserved areas, should be valued and capacitated for furthering marginalised communities' access to health services' (Data Capture).

TBAs are acceptable in some parts of the world whilst marginalised in others. The international consensus has increasingly moved towards facility birthing by a skilled birth attendant (SBA), which usually equates with a qualified nurse or midwife. Yet in rural Asia and Africa, many women still deliver at home and often with the support of a TBA. In some parts of the world hospital or facility births have not translated into better health outcomes; one speaker referred to 'obstetric violence' as a description of hospital/clinic based care received by indigenous women in Chile.

Integrated Information, Communication and Technology (ICT) solutions can strengthen health worker effectiveness. Mobile technology has potential for enhancing capacities, empowering and managing a large workforce like CHWs. Providing mobile phones to CHWs (ASHA) in India equipped them with multimedia job aids to support client assessment, counselling, early identification, treatment, and timely referral of pregnancy, postpartum and newborn complications. It is important that initiatives like this are fully costed and that there is not 'cost shifting' on to health workers (example of pilot project in Ghana, Malawi and Ethiopia). Also need to consider that CHWs may never be off duty once the community has a number to call. This raises issues discussed in the community health system section around exploitation of CHWs.

Quality

There were numerous references throughout the conference to 'quality' as a key element in the strengthening of health systems and improving health worker performance discussions. As someone eloquently put it, *'there will be no UHC without quality (Data Capture).'* A number of sessions raised both challenges and solutions to quality improvements in health systems. Quality issues ranged from data collection, to improving times of clinics, to deeper conceptual considerations of safe practice and providing care that is respectful and equitable.

Challenges

There has been a tendency to emphasise *'health service volume and human capacity with little emphasis on quality of services'* (Data Capture). It was noted that whilst *'increased coverage of health services is important, without quality it does not improve health outcomes'*. For example, *'In the Democratic Republic of Congo (DRC), facility birth rate is 88% yet maternal and new-born health (MNH) outcomes are not improving'* (Data capture). Even if quality is improved, women in some parts of Nigeria for example are not accessing facilities, there is a need to know why and address access issues. In LMICs, PHC systems tend to fall short of providing high quality, integrated and people-centred care. In addition, it is clear that: *'The wealthy get quality services, whilst the poor receive a decreased quality of care, incorrect diagnosis, slow care and disrespect of patients is high etc.'* (Data Capture).

Experiential quality needs to change as reportedly 1 in 3 patients experience disrespectful care, short consultations, poor communication or long waiting hours. Equity is needed: *'poor quality for the poor'* (Data capture). However, even when financial resources were generous for example in Liberia, there is often *'huge wastage in the system, which in turn dilutes service quality'* (Data capture). Effects of poor quality include *'preventable mortality, increased morbidity, pain, loss of function, anti-microbial resistance, loss of trust in health systems and government, waste and economic losses'* (Data Capture).

Training of staff is a critical element in improving the quality of care, but this increases cost and puts pressure on staffing levels in health facilities. Quality care must be safe care and this can be challenging in LMICs where there is little regulation of health worker practice and qualification. For example, there is often little or no regulatory requirement for pharmacy related qualifications, thus no responsibility for patient safety and clinical governance in many LMICs. In health systems that are overburdened by high demand and scarce resources, the potential for decline in quality with rapid expansion in quantity is a pressing challenge.

Solutions & Areas of Good Practice

Despite the multiple challenges of implementing and achieving quality measures across health systems there were no shortages of potential solutions and areas of good practice. There is a recognised need for collaboration and consensus on building quality to:

...articulate a shared quality vision by politicians, policy makers, providers, purchasers, managers, leaders, donors, regulatory agencies, health care facility (public and private), professional associations and citizens and patients (Data Capture)

There were good examples of new departments within Ministries of Health designed for quality improvement and monitoring (Uganda, Libya). In Mozambique, *'quality has been adapted into an operational framework for the new national Directorate for Quality and Humanization of care'* (Data capture). In Pakistan (PAIMAN 2004 -2010) and the Philippines (Bicol Emergency Health and Nutrition Project 2007-2008) national MOH have adapted and produced quality improvement guidelines and accompanying training manuals. Partnership Defined Quality (PDQ) is a methodology that engages community members alongside providers in designing, implementing and monitoring quality improvement (Medical Teams International, 2017). This has been developed through instructional videos and used in a number of countries including Liberia.

Training methods reported across presentations as being beneficial to learning included; pictorial tools and improved training packages for low literacy CHWs to improve quality of care.

Importance of phased training programmes, simple jargon free materials that reflect on the real-life experiences and go beyond theory, low dose- high frequency training is important to develop a quality culture (Data Capture).

Developing a culture of quality is needed given high attrition rates of health workers, which can mean a loss of capacity in quality care. In addition, there needs to be more follow up training evaluation to understand if health workers are applying knowledge learnt.

Quality Measures

Sessions on quality created a good discussion on what types of measures and metrics could be developed as a global standard. This of course would be challenging as not all countries are on the same playing field. According to one presentation:

Current quality measurements in LMICs are not fit for purpose: measurement should be for accountability and action. No agreed metrics at the global level on quality of health services or programmes - need common measures for the point at which patient meets provider for decision making and policy purposes (Data Capture).

In Zimbabwe, quality was monitored and assessed based on: community scorecard data, suggestion box data and individual complaints feedback. Another example is the way responsiveness is assessed through seven questions about patient health care seeking experience in SSA. The responsiveness dimensions are Dignity, Autonomy, Choice of provider, Confidentiality, Quality of basic amenities/surroundings, Communication and Prompt attention. Direct observation to determine whether clinicians when providing services follow national guidelines is another quality measure. In a SSA context, an integrated provision checklist is completed to monitor quality during supervision visits:

Yeah, there's what's called an integrated provision checklist...Once they do that, it's automatically sent to the headquarters and directors that are responsible for certain things can really analyse what's coming through, through dashboards that have been created. So there's that kind of system (Deputy Director of Planning in the Ministry of Health and Population, Southeast Africa).

The launch of the Lancet Global Health Commission on high quality health systems in the SDG era provided a 'Conceptual model for Quality' (See Figure 1). The model provides a broad spectrum of inputs as well as potential benefits of improving quality within health systems.

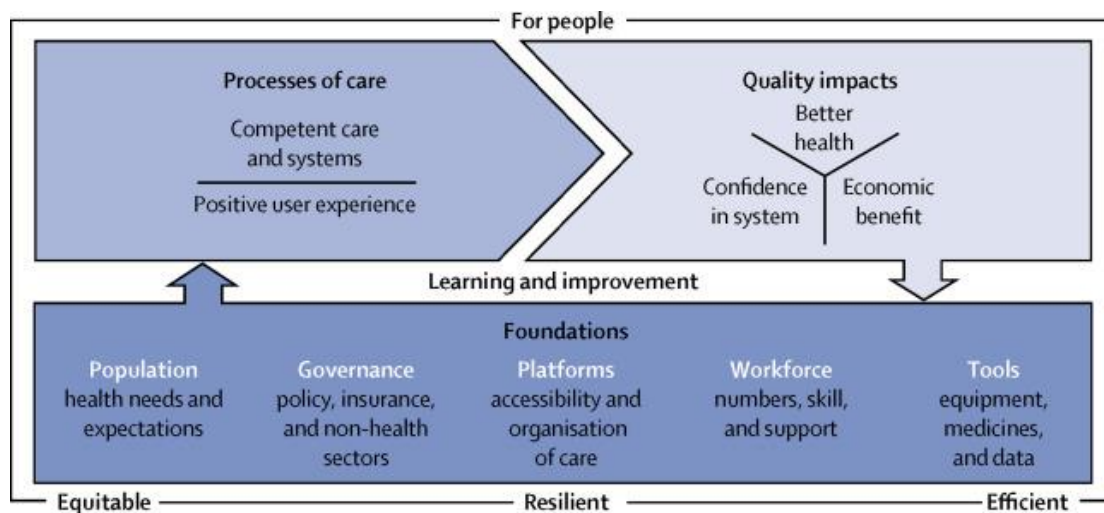


Figure 1 Catalysing health system quality in LMICs: launch of the Lancet Global Health Commission on high quality health systems in the SDG era

The improvement of health systems and health worker performance cannot be achieved without a focus on quality measures and management. A number of key actions have to take place before quality measures can be cascaded to facility level. This includes ‘quality champions’ at all levels of government including and starting with the MOH. The concept has to be developed and owned by all levels of the health system and those working in it. Many low resource settings will have to prioritise what elements of quality they want to focus on first in order to gain the highest returns.

Community Health Systems

Community health systems (CHS) are critical to providing UHC, particularly in rural areas and for marginalised communities. Linked to the Alma Ata declaration with a focus on services where people live, CHS rather than PHC dominated many of the conference sessions. Whilst CHS are in many contexts strengthening, albeit with the support of donors, they remain scarce in urban areas. For example, an interviewee from a SSA context discussed a new national community health strategic plan that aims to increase access to services via health posts and has managed to negotiate funds from donors for this:

Since 2017, we have a strategic plan, which is called the National Community Health Strategic Plan. So through that, we are trying to focus more on community healthcare delivery. We are talking about constructing about 900 health posts which are really very simple facilities where we have community health workers there, like addressing the disease before people even go to like even a health centre or community hospital, district hospital... So like for example, the construction of these centres and providing equipment for community health workers, it's all in these grants because we are trying to shift from a curative approach but with a promotive, preventive and, yeah, primary healthcare approach (Deputy Director of Planning in the Ministry of Health and Population, Southeast Africa).

Community Health Workers (CHW)

Community health workers (CHW) are viewed as critical within CHS and to delivering UHC for marginalised populations. As noted in one session: ‘In order to achieve SDGs, UHC and PHC for all, CHWs are taken as being a way of getting there. If CHWs fail, SDGs fail, UHC fails and PHC concept fails’ (Data capture). This raised many concerns related to CHWs, most already known, with reference to pay, training, progression and quality of services.

CHWs are not heterogeneous; there are many types of CHW cadre. Some paid, some unpaid. Some highly trained, many not. Some can and do progress, but this leaves gaps. Whilst not a binary picture there were gender differences noted. In many parts of SSA CHWs tend to be male and paid, whilst in the South Asian context most are female and voluntary. Zambia has a large CHW workforce and it was claimed that it was the first country to pay CHWs. This might depend though on how CHWs are defined. If you accept that environmental health practitioners (EHP) are CHWs, then this paints a different picture. EHPs in many respects are CHWs despite their enforcement role. They represent a well-trained and regulated workforce who in South Africa is also accountable to the community in which they work. However, as commented in the conference they are undervalued and only account for 0.5% of the health workforce yet do so much to protect and promote health. EHPs more often than not are working in the urban environment, as previously noted this is an area requiring more PHC and CHW input.

CHWs often work in challenging environments, whether geographical or in conflict and fragile states. Additionally, they experience tension and a mismatch of needs, demands and expectations from the health system, donors, and community. A core aim of CHWs as envisaged at Alma Ata was community mobilisation, which might be in conflict with delivering donor driven services. As noted in India, *'increasing medicalization tasks and less mobilization work are taking 'ASHA' (CHWs/India) away from the SDOH'* (Data capture). This was also noted in the Australian aboriginal health system context where Aboriginal health workers are increasingly expected to focus on delivering services to reduce 'the gap' (10-year life expectancy gap). This focus on medical interventions and acting as first responders leaves little time to work on SDOH and health improvement/community development. Although paid, they often feel at conflict with their own community and their needs. CHWs often have multiple roles like community activism and sensitisation on the one hand whilst increasing service delivery on the other. This can create challenges. Are they part of the community or the health system? Several sessions raised an important issue of embedding CHWs more firmly into health systems; however, this challenges their community activist role. Village Doctors in China previously known as Barefoot (est. 1950's) have been long-term rural community public health providers, and only formally integrated into the health system since 1995 they are now paid and regarded as part of the system.

Training and supervision remains critical for CHWs as poor-quality care impacts on health outcomes and community engagement.

Often quality measures/standards stop at the facility level yet CHWs are the 'backbone of the local service provision'. The cost of poor quality care remains an on-going problem but there is an increasing awareness that UHC cannot be achieved without quality (Data Capture).

Many speakers raised concerns over overburdening CHWs and believe that they should be resourced and compensated adequately for the work they do. Also, that there should be a move away from volunteerism, which will not improve quality or accountability. Finally, it is important that CHWs not only receive training and supervision but also have the option of progression and a career pathway like any other health worker.

MCH is a key area for CHW activity *'yet they often work in isolation and don't have training and support around high risk pregnancies'* (Data capture). There were several interesting debates related to Traditional Birth Attendants (TBAs) who are still recognised as CHWs in some settings. Delegates from South East Asia were surprised that TBAs were not part of the health system and invited to train to become a skilled birth attendant (SBA). This remains an interesting area of discussion whereby many isolated rural communities remain dependent on TBAs whether they are officially recognised or not. In one scenario, it was noted:

The MoH does not officially recognise them and provides no support or training. They receive their training from older and experienced TBAs. They are not paid but the community members trust them (Data Capture).

Again, this highlights perhaps a mismatch between community norms and expectations and what donors and/or international organisations want or expect. Knowing when an otherwise normal pregnancy becomes high risk is the critical factor here and without adequate training and support, TBAs cannot achieve their goals.

Facility and community-based health workers both paid and voluntary, represent a substantial component of the human resources supporting health services in low resource settings. CHWs are seen as the key drivers of making UHC a reality but they lack the tools and are overwhelmed with tasks. *'CHWs need to be trained, compensated, and salaried for the work they do as they play a key role in providing health services. Building from the work they already do is cost effective and feasible'* (Data capture). Finally, CHWs also need to be accountable to the government and to the populations they serve and become a genuine part of the formal health care system. For example, an interviewee spoke about a model in one province of South Africa where CHWs are commissioned by the provincial health department through civil society organisations.

Community Engagement & Empowerment

Health improvement cannot be achieved without communities engaging in health promotion activities. Community participation, one of the key pillars of PHC as envisaged at Alma Ata, is not without challenges and as noted above some CHWs primarily exist as community mobilisers. There were a number of methods shared, which aimed to engage communities with health messages and opportunities for health improvement. Some were more traditional tried and tested methods of participatory activities whilst others used more contemporary technological and social marketing methods.

The use of technology and social marketing through EHealth or MHealth methods is viewed as an important element of health improvement strategies, particularly in urban areas. A speaker from Benin talked of an initiative using social media to engage the public with health messages: *'Community participation can also be instilled using socio media such as Facebook. Creating a Facebook page with specific health topics can prompt public engagement'. This gives an opportunity for the public to interact and share ideas'* (Data capture).

However, it was noted that the coverage is mostly applicable to those with access to smart phones and younger adults who are keen users of social media such as Facebook.

It is ethically important in health systems that the priority-setting processes are designed to share power with the disadvantaged and marginalised in order to ensure that their voices and needs are included. Listening and providing a space for voice and participation in community needs and priority setting is an important part of health system responsiveness and an element of promoting quality in health systems as discussed above. The incorporation of public views into priority setting is perceived as a means to restore trust and improve accountability within health service delivery. In Kenya, for example the MANI Project in Bungoma County has used Community Scorecards as an engagement and social accountability tool through which community members' needs (the demand-side) are articulated.

Community involvement is key if UHC is to be achieved, yet this approach has not been fully explored and lessons are ongoing. There needs to be a better understanding of communities, and how health systems can support community-led and participatory governance to achieve immediate health outcomes. Peru is one of the few countries in the world that has a governmental health programme

for PHC services with legalized, regulated, and institutionalized community participation. The Cameroon experience has highlighted the need to provide accurate information to communities and strategically include village heads in this process to increase acceptability and community ownership.

There are many barriers faced while engaging with the community. How far the community is engaged could relate to factors like openness of the people and level of understanding and education. Communities should be engaged and remain partners with the health system in order to improve health outcomes. It is important to revisit the basics of Alma Ata, through integrating community health systems in the form of community participation, and strengthening citizen's voice, which puts pressure on the government so that money goes to where the need is to ensure priorities are met.

Equity

Inequalities presented were most often related to political and ethnic marginalisation, indigenous populations, gender and people with disabilities. The researchers noted that a lack of sessions addressing the inclusion of people living with disabilities was a key gap when considering universal health coverage and leaving no one behind.

Gender discussions were focused on reaching targets for maternal health but did little to address gender issues associated with other parts of the health system such as female health workers. One interviewee discussed this point:

...for example, when we defined the Essential Health Package for Malawi, one of the criterion was the group agreed that interventions that focus on women and children should really be prioritised above interventions that are utilised more by other demographic groups... you have female health workers who, for example, have to leave jurisdiction because they're accompanying husband. So that creates a lot of...like, it creates greater maldistribution of health workers... I don't think there has been a kind of explicit focus, or there has been that kind of attention to gender issues that affect the labour force, no, I don't think so (Deputy Director of Planning in the Ministry of Health, SSA).

The sessions highlighted how health equity is impacted by the history of a country, particularly where there are marginalised indigenous populations (IPs). The sessions reported that IPs are often left behind because either they do not have access to information about basic human rights, values and respect, or they cannot access it due to discrimination. As a result, they often do not participate in health decisions and can have complex psychosocial issues including substance use. IPs can have their own traditional health service provision that is rarely included within the public health system and further challenges their inclusion. One presentation suggested that channels of communication should be explored with advocacy for government and non-government agencies to discuss problems and potential joint solution identification. Where this has happened (Guatemala) evidence of reduced discrimination and better responsiveness to PHC providers has been found. Local authorities can have an impact by working closely with IPs to advocate for change at higher levels.

There is evidence that data collected for planning and prioritisation of PHC is being disaggregated at the community level to identify areas of inequity and to inform indicators for targeted universalism. This is an element reported as part of the WHO health equity assessment and response tool. The sessions highlighted a need for new concepts and mechanisms that are oriented around systems thinking and providing culturally appropriate care to strengthen health systems and ensure UHC for all nationals and displaced persons.

Data, Monitoring and Evaluation

Many countries are in the process of developing or revising indicators to measure the success of PHC.

‘Scale, sustainability and measurement. How do we ensure that we are always striving to health outcomes and that we have the end result in mind from the beginning as we are pulling together a constellation of perspectives and contributions to resolving some of these challenges? We want to be sure to keep focusing on how we are measuring, and so we can connect it to how we scale and broaden the impact of our work’ (South Africa data capture).

When considering what to measure, there is a reported need to look at process, what matters to communities and quality rather than just the inputs, outputs, outcomes and impact. All indicators need to consider content, level of its collection, frequency, specific purpose, use of data for accountability and action. Institutionalised use of data to influence programming and improve health outcomes was reported as key to planning PHC and advocating for UHC. Ensuring that a functioning integrated or inter-operable information management system is in place is necessary for planning and prioritising services and programmes. Indicators were also described as a useful tool to identify issues that need addressing and to advocate for policy change. In Indonesia for example, road injury was not previously on the agenda but now has a strategy and policy linked to the inclusion of that indicator.

Indicators can also highlight contentious areas of policy, for example, NCD targets against the Ministry of Industry wanting to increase revenues from tobacco. Having a global indicator helps these issues to be resolved. The importance of sharing draft indicators with those who will be monitored and those who will be doing the monitoring was raised as a key process needed to ensure their views and needs are understood before finalising. Better understanding and interpretation of data collection at the central level by empowering and improving capacity to read and analyse the data was stated as a need in LMIC settings.

A number of tools are being used to measure progress; however, interviewees expressed the complexity of trying to incorporate indicators from a range of sources. Having too many indicators leads to lengthy and complex data collection that was a reported challenge. For example, some countries may be using an equity tool at the district/municipal level to develop priorities and indicators which then have to be merged with national and donor indicators. There are numerous registers that health workers are required to use, one presentation stated that approximately 20% of their work is allocated to just writing the information in registers and tallying. Therefore, in terms of integration, the record keeping also needs to be explored. Separate data reporting and funding for the programs in some of the donor-funded areas is challenging. In South Africa, they had a data entry officer, which took the burden away from PHC members. This was reported as one reason for successful integration. Technology is an important building block for any health system. In Bangladesh the use of IT systems, especially in remote and rural areas facilitated data reporting. From the MoH, routine real time data is generated and sent to the ‘National Information Highway’ for decision-making and evidence-based planning at the local level. However, in urban areas, only initial steps have been taken towards data collection from NGOs and the private sector ready for analysis to feed into this planning tool.

Indicators and targets require the identification of population size in a specific geographical area; however, challenges in Mozambique were reported around estimating this correctly due to: 1. Lack of robust civil registration (births and deaths undercounted). 2. Out-dated census data (census data does not provide information below district level) 3. Census data insufficiently granular to attribute to individual health facilities. 4. Migration due to frequent natural disaster (climate change) 5. Rapidly changing administrative divisions.

Case Study from ‘Toward a measure of overall universal health coverage: tracking service coverage and catastrophic health spending in 188 countries, 1990-2017’. UHC service coverage was measured using tracer indicators that represented 5 key health service areas, ranging from reproductive, maternal, neonatal, and nutritional services to non-communicable diseases and related risk factors, and 24 sub-service areas. The authors scaled each tracer from 0 to 100, with 0 representing the worst observed performance and 100 the best across location-years. They then averaged values across all indicators to approximate UHC service coverage and estimated catastrophic health spending. This study highlights the importance of measuring UHC for all countries over time. These results offer decision-makers the evidence base needed to strengthen health systems so that they can truly deliver for all.

([https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30487-4/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30487-4/fulltext))

Monitoring and evaluation approaches

In addition to having indicators and measures, additional monitoring and evaluation to inform service performance and quality needs included; socioeconomic information, accessibility, distance to service provider, service coverage data and capability of the population to go to the health service. Monitoring and evaluation approaches are summarised in the table below.

Monitoring and Evaluation Approaches Presented
Health facility assessments and verifiable data review meetings in facilities across the state to ensure the use of data at the facility level.
Health facility scorecards were perceived to be better for patients than for the facility. It was supported by high performers and opposed by poor performers. Scorecards helped improve motivation in some cases. However, some felt it scared away patients.
Inspections at facilities were seen as legitimate and fair and built trust with inspectors or supervisors
Client/patient satisfaction surveys intended to generate evidence for improving communication, and service delivery approaches worked well. The surveys aimed to increase institutionalization of engagement and working with client feedback to build a healthcare system that is responsive to the needs of its clients. The client’s involvement helped to form a uniform view of the state of affairs and build consensus on the improvement roadmap thus fostering accountability, buy-in and use.
National monitoring checklists with indicators and HMIS functionality assessment
UHC tracers In service coverage index for UHC with the World Bank; however, service capacity and access were identified as gaps in this method. Additional measures should include effective coverage and equitable distribution of effective coverage.
Qualitative methods Many presentations raised the importance of not only measuring quantitatively but also supporting with qualitative measures. For example, the PHCPI measures for supervision in Malaysia scored high but following interviews they internally scored it lower. Other qualitative methods used included interviews, participatory action research and learning cycles. Using multiple methods such as focus group discussions as well as household surveys served to identify barriers to PHC including accessibility due to poor roads, lack of safe and affordable transport and long distance. These could be additional indicators to monitor.
Other indicators/measures reported within presentations included; rate of utilization of primary health care services, patient expenditure (In and outpatient), primary care quality, prevention of avoidable admission, disability-adjusted life years (DALYs) averted, catastrophic health expenditure, cases averted, and number of lives saved by basic package delivery (South Sudan and Madagascar).

Private sector

Urgent policy level exploration is required for recognizing and strengthening public-private links and partnerships for achieving UHC. Contracting and purchasing services from the private sector is one aspect of financial planning which created a number of critical debates:

The compelling need for contracting is informed by the need to align private health providers with public policy goals as an essential step for moving towards UHC' (Data capture).

Contracting in this context was defined 'as a formal agreement between a government and private providers to deliver agreed services and outputs, over a stipulated time frame (Data capture).

Contracting out services to the private sector has worked well in some countries and not so well in others and this raises the need to look critically at how contracting with private providers is designed, managed and regulated in LMICs. The MDGs monitored public services but now there is a need to understand and monitor the private sector, which is challenging and takes time. What services are offered by the private sector and how the public uses them is often not known by governments. In addition, this raises questions about quality and at the point of care, are people receiving the treatments and standards we know they should expect that are applicable across all populations and vulnerable groups?

Nigeria Case Study: The private health sector in Nigeria is heterogeneous and has multiple players ranging from large private investors to small pharmacy shops. The rapid growth of the private sector is putting enormous strain on the government and its capacity to regulate the sector. Whilst there are available legal frameworks for regulating the health sector, which includes the private sector, this can be challenging to implement where governance is weak. In addition, standards have been reduced due to poor budgetary allocations. In addition, there is no well-established database of private health providers, and those that do exist are out of date, some as old as seven years. Most state governments are not even aware of the number of private sector providers within their territory. There is a need for a well-established link between the public and private care sectors.

It is not always clear if the private sector is 'for-profit' or 'not for profit'. The focus in most sessions was on for-profit and how these providers mainly served middle and upper income populations:

... people who are wealthy and have the ability to do so, would actually not access the public sector. Whereas in the private sector, you know, there are more health workers, there's better type of care from studies that have been done, there are so many facilities you can access quite easily. But, of course, the services are costly (PHC researcher from an East African University).

There were more discussions about large corporate sector providers who own and run hospitals, clinics and lab services for example as opposed to smaller informal clinics, pharmacies or drug shops. However, one presentation stated the need to engage private drug shops as community health providers for providing PHC services.

... there are several drug shops that also are supposed to really be part of the primary healthcare system, but some of those have not been fully integrated and recognised as part of the formal health system. Yet, if someone, for example, goes to a CHW and they don't have medicine to treat a sick child, they're going to rush to a clinic or a small dispensary. So, we need to do a bit more to ensure the private sector really comes on board fully and that they are really seen as core partners in promoting health in Uganda (Data capture).

Likewise, the need to better engage and support small private providers who are for-profit but not necessarily motivated by large profits is essential when thinking about PHC, particularly in urban areas:

...it's the lower level providers who really could very easily get left behind if they're not represented. And they're the ones who are just trying to put money...put bread on the table for their families...often their main motivation is actually providing health services to their communities...they're not business people, they're not as well supported, they're the ones who can often suffer the most when there isn't clear communication when there are changes in how health insurance works, et cetera (Data capture).

An international NGO that is working in two SSA countries to support governments to better link private providers to national insurance mechanisms for developing PHC was interviewed. The interviewee reflected on their experience and expressed the need for better communication with small and medium sized providers to achieve PHC:

And there is not very good communication, particularly with the small and medium size private providers of healthcare ...there's a reticence in a lot of those smaller providers to actually even be involved in those national purchasing mechanisms, because they don't understand the benefit to themselves and they hear anecdotally that actually it's not really worth their while from a business perspective to be involved... There are a lot of administrative and bureaucratic hurdles to put them off. And also, things like if there's a capitation payment for primary healthcare, for a provider who's only ever received out-of-pocket payments, to understand the concept of a capitation payment, if it's not very well communicated, can be quite confusing. So those kinds of levels of detail need to be really thought through in that communication, and often, for a range of reasons, they're not. (International NGO working in two SSA).

The interviews uncovered deeper aspects of private sector usage when planning UHC. In South Africa, one interviewee explained that people do not simply split between using public and private facilities but use them interchangeably:

So there are some people that are not insured that would go to a primary care...would go to a GP, a private sector GP for convenience when they wait too long in the public sector. And there would be people that are insured that would come to the public sector, because in our facilities we render a bigger range of services than the GP would offer (Provincial head of Health Services, South Africa).

Regulation and Quality within the Private Sector

Regulation of the private sector was discussed on many occasions in the conference. The private sector often fills a vacuum in health services that is left by the unavailability or inadequacy of the public sector, yet it is still largely unregulated (Bangladesh, Somalia, Nigeria, Guatemala). Issues raised were regulation, quality, OOP leading to catastrophic spending and being motivated by profit and not by the desire to ensure health for all.

'The Private sector in many LMICs is characterised by extreme fragmentation/unregulated, with numerous small sized private providers operating clinics and offering a limited number of services at a low level of quality. This limits their ability to be accredited to health insurance and other purchasing schemes. Contracting and managing claims from numerous small private facilities poses an administration challenge for insurance agencies and Government purchasers' (Data capture).

In one SSA country, smaller providers were often unaware that they were delivering poor quality services:

I think most providers, but not all, recognise that they need to provide a quality service, otherwise their clients won't keep returning to them. But depending on their level of training and their qualifications and experience, their interpretation of what quality is can be very variable...they'll be happily providing services without realising that actually, they could be putting the health of some of their clients in danger by not adhering to correct infection prevention protocols... (International NGO working in two SSA).

Across interviews and presentations, the need for governments to have capacity to manage and regulate private providers was raised. This includes; being able to assess what private health providers are doing/providing, what data and data management skills do they have, what kind of financial monitoring systems do they use, what pricing mechanisms do they use? Governments need ways to ensure compliance for financial reporting and auditing. In some cases, these tasks remain largely with private providers and to some extent insurance agents. Governments need sufficient resources to monitor and ensure performance is of good quality. In countries that have minimal control over the private sector, there are concerns that they take over the health system, leading to rising inequalities and poor-quality services:

...It is not private public partnership; it is basically a private party takes over your system, where taxpayer has invested money. Private partnership works in the situation where the person who contracts out is strong enough to dictate the terms of engagement, correct? Whereas in the private sector, what happens, I have seen in my own district, the girls just are taught on job and they're touted as nurses in the private hospitals, they're not even qualified nurses. Just because they provide care people think they're nurses. We have found them, they are not nurses. And that is why many times they give wrong injections; they're not able to read proper English. So I would say private partnership will be welcome when the contractor, means the public system is strong and then you say, okay, see, I have...I need one technology here, I need one technology there (Data Capture, India).

Tensions exist around the motivations of the for-profit private sector and their focus on selling the services and products with little or no regulation. One interviewee explained that in their country, private sector GPs would 'over-service' and prescribe medicines, as it was necessary for their income. Whereas in the public sector there had to be a process of prioritising the use of services due to constrained budgets. An example was given in South Africa, where there is a drive for antibiotic stewardship with new initiatives for clinical governance and decision-making to ensure services delivered were cost effective. Clinical audits were introduced to monitor the private sector and understand prescribing patterns. This was followed up with standardised clinical treatment protocols and decision-making groups to try to align private and public providers.

Regulation efforts such as obtaining a licence to provide services were in place in some settings but were tokenistic and easy to attain with a lack of monitoring and supervision. The interviews revealed that in some cases ministries feared the private sector and were reluctant to challenge them. It was suggested that contracting to the private sector was politically driven which could explain this fear.

One interviewee explained his fears:

In the country, many people, they thought that the solution is with the privatisation of the health sector... And they brought many advisors from the private sector. Usually, you find the advisor or the minister or deputy minister originating from the private sector. But unfortunately, those people, they don't think about the social values or the good of people, they think about their own business point of view. Because they don't think health as a right or a need, they think health is a benefit, you see...But when the Ministry of Health and the government is weak because of this instability, they cannot set up the regulations, rules, they cannot measure the

performance of the private sector, they cannot monitor the contractual process. And the private sector, they do have all the resources to do so (Director General of Health, post-conflict, North African setting).

Other mechanisms of regulating quality within the private sector included a complaints system for the public; however, these were not well used or did not reach regulatory authorities unless the issue was extreme. Health insurance schemes were put forward as a means to regulate private service providers especially around cost and ensuring they are following standard treatment protocols.

India provides a plethora of examples of private health care initiatives in the primary care urban setting, but do not provide PHC as envisaged at Alma Ata. In Bangalore, 'the Family Doctor' is a private primary health network that borrows its model of delivery from a popular coffee chain franchise, which promotes service quality through standardised practices and procedures learned from the foodservices industry. Technology assisted health care is a growing trend which can fill some gaps in service; however, these focus on treatments and not prevention. Perhaps more worryingly one speaker, on more than one occasion, claimed that '*regulation kills innovation*'. Clearly, this raises challenges to governments and citizens alike. Health protection is a critical element of public health systems, yet more often than not, it is side lined.

Conversely, some presenters and interviewees reported that the private sector were better at regularly monitoring quality than the public sector. Reportedly, the public health system in Brazil were not measuring quality, whereas almost all the private providers are measuring quality of their physicians and their teams and if it is efficient for patients.

In some countries, governments are finding ways to work in partnership with the private sector to meet their own targets. For example, in one province of South Africa, private health providers are given free family planning and vaccinations to achieve UHC targets on behalf of government. This partnership allows for monitoring quality and utilisation measurements through contractual agreements:

They must sign a contract with us and then we monitor the contract. We provide the supplies to them; they give us the statistics and utilisation stats. And we reserve the right to inspect and investigate, and if we find that they are selling or whatever, we can terminate the contract...so it's quite a good, structured process (Provincial head of Health Services, South Africa).

NGOs and Faith Based Organisations

In some cases, NGOs and FBOs were contracted in by governments or donors to deliver PHC services short term with the aim to have these eventually transferred to public bodies; however, the transition has not happened in most examples. An interviewee highlighted corruption as a barrier to this transition as government officials who had a stake in their functioning often owned local NGOs. A presenter from Ghana stated that strengthening the relationship between Faith based Healthcare Providers (FBHP) and the government would help to move towards achieving UHC. The Wadhvani Initiative for Sustainable Healthcare (WISH) is a public-private health service partnership that involves outsourcing some of the primary health facilities in remote geographic areas in the state of Rajasthan to a NGO. Likewise, in one SSA context, mission providers through service level agreements deliver 30% of primary health care services:

Yeah, I think the key thing is this issue of service level agreements that government has with mission providers. About 30 per cent of health services are provided by mission healthcare providers. And these are mostly located in rural facilities...in rural areas where government have no facilities. And they also charge a user fee... Because the policy is that every [citizen] has to access the basic health package free at the point of access. So, you just want to equalise that in

catchment areas of government facilities and also in the catchment areas of the mission providers (Deputy Director of Planning in the Ministry of Health and Population, Southeast Africa).

Whilst this system allows for monitoring, quality issues were still apparent, and a unit was established to manage mission providers:

So, what we did was to establish a unit...so we have a secretariat that manages all these mission healthcare providers, so we have established a unit within there. That looks at all the data that's coming in, because we pay these facilities on a case-by-case basis. So, there is a team that looks at...that analyses the data that's coming from the facilities... So, when such kind of issues arise, because people are analysing the data, then the quality management director, for example, take action, visit the facilities and see what's happening (Deputy Director of Planning in the Ministry of Health and Population, Southeast Africa).

District level health officers also provide supervision within these facilities:

Like, district health officers also have responsibility for monitoring the mission facilities under their...in that jurisdiction. So they do regular supervision just to ensure that, yeah, they are doing their work in line with the standards and guidelines, I think that sort of thing... they will do quarterly visits to all health centres in the district... and mentor if there's need for that or, you know, like correct things if there's need for correction (Deputy Director of Planning in the Ministry of Health and Population, Southeast Africa).

Challenges were reported by FBOs and NGOs related to working in partnership with governments. FBOs reported concerns about timely repayment, low reimbursement rate and rising empanelment standards, which are particularly challenging for facilities in resource poor areas. They also faced financial and human resource constraints. Government officials were reported to micro-manage NGOs in some settings, treating NGO workers as government servants. Some NGOs struggled with resources as the government refused to release funds, an NGO member quoted; *'You call me a contractor but do not give me the rights of a contractor'* (Data capture).

Overall, the presentations and interviews highlighted a need to gain a better grasp on the level of PHC service provision by the private sector and how to regulate quality and maintain equity. Whilst the potential is recognised, there is not enough evidence:

'...The potential of private sector engagement is increasingly being recognised in the context of UHC, deliberations are mostly ideologically influenced because of the lack of evidence' (Data capture).

There is currently also a concern that governments are focused more on managing private sector contracting and performance, which could lead to a decline in efforts to deliver public services to the poor.

One of the solutions posed to the above gap is to engage small/medium local providers early on in the process with a focus on linking district or county level health systems with these providers:

Really there's a lot of soft power held by those local level national health insurance agents, who are the ones who mediate the relationship officially between the policymakers and the designers at a national level, and the providers at a local level. They have influence over where, under capitation, for example, where clients are capitated; they have influence over claims processes, and influence over any kind of communication about changes to the package. (International NGO working in two SSA)

Smaller providers also tend to be overlooked during efforts to improve quality:

...going back to this idea of having, I suppose, agency and voice, the smaller providers, if there isn't someone campaigning on their behalf, they get left behind. So, you'll have providers who need to be told they need to upgrade their facilities in some way, they don't really understand exactly what that means. Even when they do it, they find it hard to get the attention of the local and national health insurance agent to come out and make sure that they're adhering to those standards...And that's something that I think there's a space for in quite a few countries is organisations or structures that can provide that voice and bring that voice of a whole plethora of smaller providers to government, to have a discussion that is meaningful to both (International NGO working in two SSA countries).

Conclusions and Final Thoughts

The conference provided a plethora of rich discussions on how to achieve UHC and the role that the private sector plays or could play in this. PHC is clearly still an important method to deliver public health services and interventions to communities but was not always referred to. There were discussions about community health systems, which seemed to be the preferred terminology in rural settings, whilst in urban areas health care is dominated by hospitals, clinics and small pharmacies. It is in this urban context that private for-profit health service providers have found a market due to inadequacies of the public health sector. These private providers are often unregulated and are not working to the national health policies and strategies. Private for-profit service providers are rarely interested in prevention and public health approaches; or what is the WHO's vision of PHC. Given that the public sector can barely function at times and particularly in low resource settings, it is the 'not for profit' private sector which sits more comfortably in delivering PHC. Clearly, the future has to be about partnerships and not competition. Methods for developing PPPs remain in its infancy in the health sector and there is much to investigate and learn about this.

On a more positive note, there was no lack of enthusiasm from conference delegates and speakers and particularly those from LMICs working in challenging environments. There is much pride amongst SSA delegates in their health systems and commitment to health for all. Uganda, Liberia, Malawi, Ethiopia and Kenya are developing more robust data collection and monitoring for quality in health care performance. Learning from UMICs such as South Africa can provide a number of workable solutions to scaling up health insurance and PPP working. Bangladesh and Nepal who have improved MCH remarkably under the MDG platform are working towards tackling other health challenges including rapid urbanisation and rising NCDs. Governments and their international partners in fragile and conflict-ridden states are doing remarkable work despite the challenges. In challenging settings, delegates working within the health sector are finding ways to shape PHC and to advocate for UHC despite having to convince government leaders of its value against clinical, hospital-centric beliefs. They are asking for evidence and support. Thailand has been implementing UHC for over 10 years and were honest and willing to share the challenges they faced and the lessons learned. The conference also showed that changing contexts such as rising urbanisation, increasing conflict and fragility with growing numbers of refugees means that health systems must be responsive, and global regions need to work together to manage these shared health challenges.

Health for all is not possible without multi-sectoral collaboration and strong partnerships between governments, the private sector and citizens. This conference has provided a platform to identify these challenges but also the opportunities and the success stories. In one session, the speakers were asked to discuss their interventions with respect to Failing, Learning and Adapting. Health interventions do not always work the first time or take off; importance of reflection, evaluation and analysis. Should the future be about building health systems, or rather building systems for health?

References

- BITTON, A., RATCLIFFE, H. L., VEILLARD, J. H., KRESS, D. H., BARKLEY, S., KIMBALL, M., SECCI, F., WONG, E., BASU, L., TAYLOR, C., BAYONA, J., WANG, H., LAGOMARSINO, G. & HIRSCHHORN, L. R. 2017. Primary Health Care as a Foundation for Strengthening Health Systems in Low- and Middle-Income Countries. *J Gen Intern Med*, 32, 566-71.
- FOX, A., GARDNER, G. & OSBORNE, S. 2015. A theoretical framework to support research of health service innovation. *Aust Health Rev*, 39, 70-75.
- GALE, N. K., HEATH, G., CAMERON, E., RASHID, S. & REDWOOD, S. 2013. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13, 117.
- KRESS, D. H., SU, Y. & WANG, H. 2016. Assessment of Primary Health Care System Performance in Nigeria: Using the Primary Health Care Performance Indicator Conceptual Framework. *Health Systems & Reform*, 2, 302-318.
- PRIMARY HEALTH CARE PERFORMANCE INITIATIVE. 2017. *Spurring Improvements in Primary Health Care* [Online]. Bill & Melinda Gates Foundation, World Bank Group, and World Health Organization,. Available: <https://phcperformanceinitiative.org/> [Accessed May 1st 2018].
- SIRIWARDHANA, C. 2015. Promotion and Reporting of Research from Resource-Limited Settings. *Infectious diseases*, 8, 25-29.

Appendix 1 – Data Capture Framework

Field building dimension
Project title and presenter(s)
Research focus and level of the health system (local, national, regional, Global) If more than one level, specify how?
Contextual and political factors What is the contextual environment; e.g. fragility, conflict, post-conflict, middle, low income? Is the research focused in a particular context e.g. rural/urban/migrant/border communities? Are there any current or historical political tensions or challenges to consider? How is the health system currently structured e.g. pluralistic or uniform under government administration? What are the links with regional, national, local health plans, goals and visions? What other social factors need to be considered for PHC provision i.e. education levels, religion, gender divisions, hierarchy, power differentials, traditional norms ?
Innovation/service improvement What PHC service improvement policies/strategies/interventions/service integration/best practices or cases are discussed? If relevant, how is the private sector engaging in the provision of PHC services? Is there support for the innovation or service improvement in PHC or by a private sector provider? What modalities are used, specifically by the private sector in service delivery? What frameworks are used? How is PHC service provision being measured (including any services provided by the private sector)? How is success measured at each level of the system? e.g. indicators/measures/reporting methods? What targets are used (technical quality, experiential, referrals, service integration)? Are any views expressed regarding pluralistic health care delivery approaches with the private sector? What barriers to the innovation or improvement are there? Is the innovation/service improvement sustainable? Does the session discuss exit strategies or medium to long term goals or is it a time limited intervention?
Organisational factors and actors Is the organisation from the private or public sector? Who are the key actors and implementing partners? What type of organisation(s) are they and what other organisations/institutions are involved (international/national/regional/local/donor/private/public)? What roles/support does the organisation provide to local or national partners? Are they in partnership with other countries? Do they network with external organisations?
Governance and Leadership (A1) What routine data reporting or other measures are in place to manage service quality, measure equity in access to PHC and regulation (quality management infrastructure)? What typologies and evidence is in place to monitor effectiveness of such improvements? Is there evidence of social accountability through communities, civil society and other stakeholders? In the case of services delivered by the private sector, what is the relationship with the government? How are providers selected? How is equity in access guaranteed by the private sector or through government regulation?
Financial factors and health financing (A2) What sort of financial support and payment systems are in place? What is being spent on primary health care? Is PHC adequately funded to ensure access, provide protection against catastrophic expenditures, and ensure equitable use of resources? Are there sufficient funds available at the facility level to cover recurrent and fixed costs? (B5) Where does the funding come from; donors/national funding/other funding pathways/contracting agreements/services purchased/purchasing agreements? In the case of the private sector, how are services defined, contracted and paid for? Has a sustainable funding source been identified and is it secure? Is there any changes in aid commitments? What budgetary planning is in place? Is there an evaluation strategy to examine cost effectiveness?
Adjustment to population health needs (A3) Is there evidence that delivery of PHC service/intervention is flexible enough to adjust to and best serve the needs of the population? What surveillance and community based research is undertaken to understand need and inform priorities? Is there evidence of innovation and learning?
Inputs (B1-B3) Are essential drugs, vaccines, consumables, and equipment available when needed? Are there enough health facilities to serve the population, and are they appropriately distributed? How are health facilities or services linked to information systems, including systems hardware and records and is it appropriate? How are private sector services linked into such systems?
Workforce factors (B4) Is there evidence that there are sufficient staff with an appropriate combination of skills in PHC services? Is the workforce paid or voluntary? What type of workers are discussed? For example are community health workers or close to community providers discussed? Are they part of the health system workforce or are they part of a workforce from other sectors? What staff selection and recruitment processes are in place? What level of staff involvement is there in the implementation and decision making processes? What policies support the workforce development? What is in place regarding education and training provisions and processes? How is health workforce managed by the private sector regarding quality standards and training?
Population Health Management (C1) Are local populations engaged in the design and delivery of health services to ensure that their needs and priorities are met? Is there evidence of local priority setting? How are the community engaged? How are communities in a given facility and/or geographic area assigned to a primary care provider or care team? Is there evidence of active or proactive population outreach? Is there patient demand for healthcare from private providers?
Facility Management and Organisation (C2) . Are PHC facilities organized and managed to; promote team-based care provision, use information systems, support staff, conduct performance measurements and management to drive continuous improvement?
Access and availability (C3-C4) Do people have financial, geographic, and timely access to PHC facilities? Are primary care facilities available, competent, and motivated to provide safe and respectful care? How is equity in access measured and guaranteed in both public and private providers?
High-Quality Primary Health Care (C5) What evidence is presented around ensuring PHC services are of good quality, meeting peoples' needs, and connected to other parts of the health system? Are they acting as the first-contact point? Are they accessible, comprehensive, co-ordinated, and can they provide continuity? What focus is on person-centeredness? Is there any evidence of results/measures of community engagement and accountability? What interpersonal and relational dimensions of primary health care, including trust, respect, communication, and improved self-management and activation are included? What barriers/challenges does the context present to improving PHC and private sector service quality? In the case of the private sector how is service quality assessed, monitored and reported? Does the private sector engage with communities? If so how and at which points?
Outputs and outcomes (D1, E1- E5) Does the PHC system offer high-quality services across the lifespan? Does PHC reduce the number of deaths and improve health? Does the PHC system respond quickly to the needs of the population? Are health outcomes equitably distributed across society, by geography, education, and occupation? Are resources used optimally to improve health outcomes? Is the PHC system able to continuously deliver health care, regardless of political or environmental instability?

