REPORT OF THE EXPERT CONSULTATION ON PRIMARY CARE SYSTEMS PROFILES & PERFORMANCE (PRIMASYS)

Organised by The Alliance for Health Policy and Systems Research with support from the Bill & Melinda Gates Foundation and in collaboration with the WHO Service Delivery and Safety Department

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"We need to reignite global interest in primary health care to save more lives; PRIMASYS will serve as a catalyst for this movement."
Nosa Orobaton, USAID/Targeted States High Impact Project, Nigeria

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Healthy policy and systems research
Complex adaptive systems
Case studies
Coordination and integration of care
Health systems strengthening
Low- and middle-income countries
People-centered care

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Acronyms

CBL	Context Based Learning
HIC	High-Income Countries
HPSR	Health Policy and Systems Research
HRH	Human Resources for Health
LMIC	Low- and Middle-Income Countries
LOP	List Of Participants
NHM	National Health Mission
PHC	Primary Health Care
PHCPI	Primary Health Care Performance Initiative
PRIMASYS	Primary Care Systems Profiles & Performance
SDG	Sustainable Development Goal
UHC	Universal Health Coverage
CHW	Community Health Worker

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SECTION ONE: MEETING OVERVIEW

1. Introduction

As the global health community is pushing for ambitious goals of universal health coverage and health equity in the post-2015 development era, there is increasing interest in frontline healthcare delivery systems, including access to and utilization of primary care in low- and middle-income countries (LMICs). A wide array of stakeholders including development agencies, global health funders, as well as policy planners and health systems decision makers, need a better understanding of the primary care schemes, in order to plan and support complex health systems interventions. The knowledge gap concerns strategic information on primary care systems at national and subnational levels in LMICs, providing insight on entry points into healthcare systems in order to improve implementation, effectiveness and efficiency of health programmes.

Primary care "forms the foundation of health systems, ensuring all people stay healthy and get care when they need it."(PHCPI, 2015) Effective primary care systems create an environment where "people and families are connected with trusted health workers and supportive systems throughout their lives, and have access to comprehensive services ranging from family planning and routine immunizations to treatment of illness and management of chronic conditions." (PHCPI, 2015)

There is a need to draw cross-cutting lessons across different settings and systems, so as to inform the organization of primary care schemes in LMICs. We need more evidence on successes and failures in improving access to, and performance of primary care. The Alliance for Health Policy and Systems Research (Alliance), in collaboration with the Bill & Melinda Gates Foundation, is leading a new portfolio of work entitled **Primary Care Systems Profiles & Performance (PRIMASYS)**. This project aims to bridge the knowledge gap on frontline healthcare delivery systems at national and subnational levels, and provide user-friendly information to stakeholders working in primary care systems in LMICs.

This initiative will be implemented by following a two-step approach:

1. Developing hands-on case studies summarizing primary care systems in LMICs

The Alliance HPSR will develop a set of twenty (20) case studies of primary care systems in selected LMICs. The case studies will be drafted as easy-to-read factsheets, providing practical and actionable information on key aspects of primary care systems, including but not limited to primary care financing, embeddedness of primary care into healthcare systems, scope, quality and coverage of primary care, organization of frontline services, costs, utilization of services, primary care policy planning and implementation, and monitoring & evaluation of primary care systems performance.

2. *Drawing cross-cutting lessons across countries to inform the performance of primary care systems*

The case studies will serve as the basis for a comparative analysis, which aims to draw cross-cutting lessons and to better understand the determinants of key successes and failures of primary care systems in low- and middle-income settings. The analysis will help move forward the science of primary care, as well as reflect on the generalizable lessons to inform larger policy debates about the role, performance and responsiveness of frontline services to improve population health worldwide.

In order to inform the planning and implementation of this programme of work, the Alliance HPSR convened an **Expert Consultation on Primary Care Systems Profiles & Performance** in Geneva on 22-23 July 2015 (see Annex 1 for meeting agenda). The Expert Consultation assembled a set of key global experts on primary care, as well as policymakers and researchers from LMIC-based institutions (see Annex 2 for meeting participants). The overall aim of the Expert Consultation was to reflect on the science and organisation of primary care and healthcare delivery systems in LMICs.

1.1. Objectives of the Expert Consultation

The specific objectives of the Expert Consultation were:

1) to devise a strategy for the development of country case studies and the analysis of cross-country lessons; and

2) to inform the development of tools for collecting, reporting and analysing data on primary care systems.

The expected outcomes of the expert consultation were listed as:

1) a strategy to conduct the case studies;

2) a standardized template for data collection and reporting; and

3) a strategy for the post hoc comparative analysis.

2. Towards a better understanding of primary care systems

Health systems research, including research on primary care systems and universal health coverage (UHC), still accounts for a very small portion of funding. Only 10% of health policy and systems research (HPSR) conducted globally concerns LMICs, where health systems are struggling the most. Furthermore, the majority of research on LMICs remains primarily conducted by researchers from high-income countries (HICs).

It is against this backdrop that the PRIMASYS portfolio of work was developed, in order to reduce the knowledge gap on primary care services organisation in LMICs. In this regard, there is a need for valid and robust evidence on LMIC primary care systems aiming to:

- inform national health plans and health systems reforms, and
- guide global health stakeholders' and development agencies' programmes.

Most research to date has focused on measuring service performance and outcomes. Yet, the need for evidence is particularly dire on the causal chain between inputs and outputs in primary care services delivery. The knowledge gap has been described as the "black box of primary care" (Figure 1), and numerous voices are calling for more research to unpack the black box and understand PHC patterns and possible mechanisms of progress, in order to better plan and implement health systems interventions and reforms.

Figure 1 - ***Black* box of primary care services delivery**

Source: Primary Health Care Performance Initiative (PHCPI)

3. Contribution of PRIMASYS

PRIMASYS represents a small grant scheme (USD 15,000) to support the development of 20 hands-on case studies summarizing primary care systems in LMICs. The case studies will be developed over the period 2015-2018, and countries will benefit from technical and scientific support to collect and report the primary and secondary data pertaining to primary care services, structures and processes. Data and information collected will in turn inform a *post hoc* analysis of PHC systems, in order to draw cross-cutting lessons across countries and to inform an assessment of performance of primary care services in LMICs. As such, PRIMASYS will put forth a health systems approach and will encompass methods pertaining to systems thinking to understand the systematic factors, processes, and pathways underpinning and explaining outcomes of primary care services delivery.

To inform the development of the strategy for the conduct and assessment of country case studies, the PRIMASYS Expert Consultation included presentations on reforms and decentralization of primary care systems in selected LMICs, namely Thailand, India, Malawi and Brazil.

4. Country Experiences

4.1 Primary care and decentralised health systems:

4.1.1 Lessons from Brazil

Presenter:
Dr Airton Stein
Public Health Department - Federal University of Health Sciences - Ufcspa
Health Promotion - Ulbra
Coordinator of HTA Unit of Conceicao Hospital
Porto Alegre, Brazil

Following a constitutional reform in 1988, Brazil implemented a scheme of universal, comprehensive access to sate-run health services financed by general revenues. In parallel to the public scheme, private insurers also provide supplementary plans for the healthiest and richest 25% of the Brazilian population. Health care management is decentralized in the country, aiming to provide a voice for civil society and to center decision-making and service delivery on health system users.

Positive characteristics of the Brazilian primary care system include: delineated functions between central and local government levels, strengthened capabilities and performance at each level, and community participation as a building block of equity. On the other side, negative traits include fragmented care and consequential overtreatments, lack of health promotion, wide variability on quality of care and PHC coverage in different cities, dearth of accountability and insufficient budgets. The Brazilian health system is at a turning point of its history. After a recent economic boom, the country is now facing economic decline and social unrest, stressing the Brazilian health system, while the latter still aims at promoting access to quality PHC.

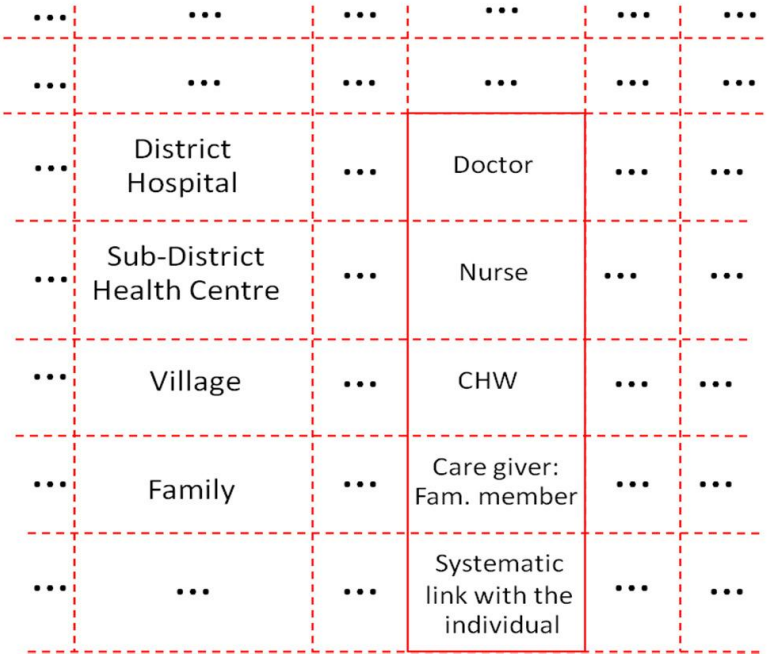
4.1.2 Lessons from Thailand

Presenter:
Dr Yongyuth Pongsupap
Senior Expert
National Health Security Office
Thailand

The reform of primary care services delivery in Thailand followed a progressive decentralization of care and push towards universal health coverage. The country introduced in the 2000s a “Matrix Team” structure, connecting the four levels of care of the district health care system: family, village, sub-district health centre and district hospital (Figure 2). The Matrix Team includes a doctor (district hospital), a nurse (sub-district health centre), a community health worker (village) and a caregiver/family member (family). In 2007, Thailand introduced a

"Context Based Learning (CBL)" approach, in order to strengthen the capacities of the matrix teams. In 2015, the country is now pushing forward a paradigm of area-based and people-centred system, via the establishment of District Health Boards as the management body to support the matrix teams.

Figure 2 - Characteristics of the "Matrix Team"



4.1.3 Discussion on decentralization of primary care

Lead discussant:
Dr Anbrasi M. Edward
Associate Scientist
Department of International Health
Johns Hopkins Bloomberg School of Public Health

The discussion was centered on the main challenges pertaining to decentralization of primary care services in low- and middle-income countries. It was highlighted that decentralization movements have been accompanied by a share of controversies and criticisms focusing on fragmentation of care, push for local political gains and lack of efficiency in the allocation of resources. To address the challenges of fragmentation of care, human resource strategies are mandatory to ensure continuity, quality and safety in the care process. An emphasis on team-based approaches and process of care across all levels of the health system has also been heralded as an important means of addressing these issues, especially in a global context where most community health worker teams are overburdened with expectations and would benefit from more support and streamlines processes. In the Thai health system, operational and administrative implementation have been delineated, and there is a need to document and learn from this process.

4.2 Primary care organisation and reforms

4.2.1 Experience of India

Presenter:
Dr Rajani Ved
Senior Advisor
National Health Systems Resource Centre
& Chair, Task Force on Primary Health Care
Ministry of Health and Family Welfare
Government of India

In 2013, the National Rural Health Mission was reformed to establish the National Health Mission (NHM), with substantive efforts towards strengthening health systems and primary care services. Over 75% of additional resources were devoted to primary health care and to integrated care within District Hospital (very little investment in tertiary care). The salient issues and challenges pertaining to primary care services organisation in India are:

- Governance reforms focused on efforts to streamline funds inflows, but many difficulties persist.
- Human resources innovations and reforms have focused on improvements in supply and expansion of workforce across all cadres, as well as multi-skilling and financial/non-financial incentives.
- Setting standards for a minimum set of service guarantees and infrastructure requirements to improve access and coverage
- Nation-wide insurance programme, now including primary care, only covers ~30% of the population
- Experiences in public-private partnerships (contracting in/out) have often been negative.
- Very little action at the local level using local data (need for surveillance data to support local planning and action)
- Caveats in regulatory reforms: absence of norms about government doctors practice in the private sector; largely unregulated informal sector
- Lack of integration: “unless somebody goes to a primary health centre, they are unlikely to receive care for primary health services”
- ~1 million health workers are involved in fostering community engagement in the country

4.2.2 Experience of Malawi

Presenter:
Dr Humphreys Nsona
Head, Integrated Management of Childhood Illness
Ministry of Health
Malawi

The organization of primary care services in Malawi is burdened by the weakness of the country's health system to support first level healthcare delivery, as higher levels of care fail to sustain service delivery at lower levels. Numerous challenges have been identified to strengthen primary care in the country, including but not limited to: addressing failures to saturate interventions implementation and competing priorities. The next priority steps identified include:

- Moving from disease surveillance to community based preventive and curative services implementation;
- Creating a hub for primary care at community level (e.g. health surveillance assistants and packaging of services).

4.2.3 Discussion on primary care organisation and reforms

Lead discussant:
Dr Lilian Dudley
Head, Division of Community Health
Faculty of Medicine and Health Sciences
Stellenbosch University, South Africa

Discussions focused on the challenge of health systems' support to community health workers. CHWs play a pivotal role in advocacy and health promotion, taking into account social determinants and environmental issues, yet health systems cannot delegate all responsibility for primary health care to CHWs. The latter are not the only solution to primary care service delivery, and they should be viewed as part of a larger, integrated system. For instance, the strong cadre of community based health workers in India presents a great opportunity, yet it requires at the same time strong support by other levels of health workers.

- Important to keep in mind that there isn't an absence of primary care systems in the settings assessed.
- "How do we define integration?": we cannot ignore the other levels of care when focusing on primary care and there is a need for strong linkages
- Primary health care can be viewed as a philosophy-based approach as well as a level of care, the latter making it operational.

- In Brazil, similar to India, there is a low level of uptake of medical students involved in primary care
- We need to address gaps between principles and implementation in primary care
- We need a better understanding of the location of primary care services delivery: health centers vs hospitals performing the functions of primary care?

5. Primary care in complex health systems

5.1 Towards integrated primary care systems

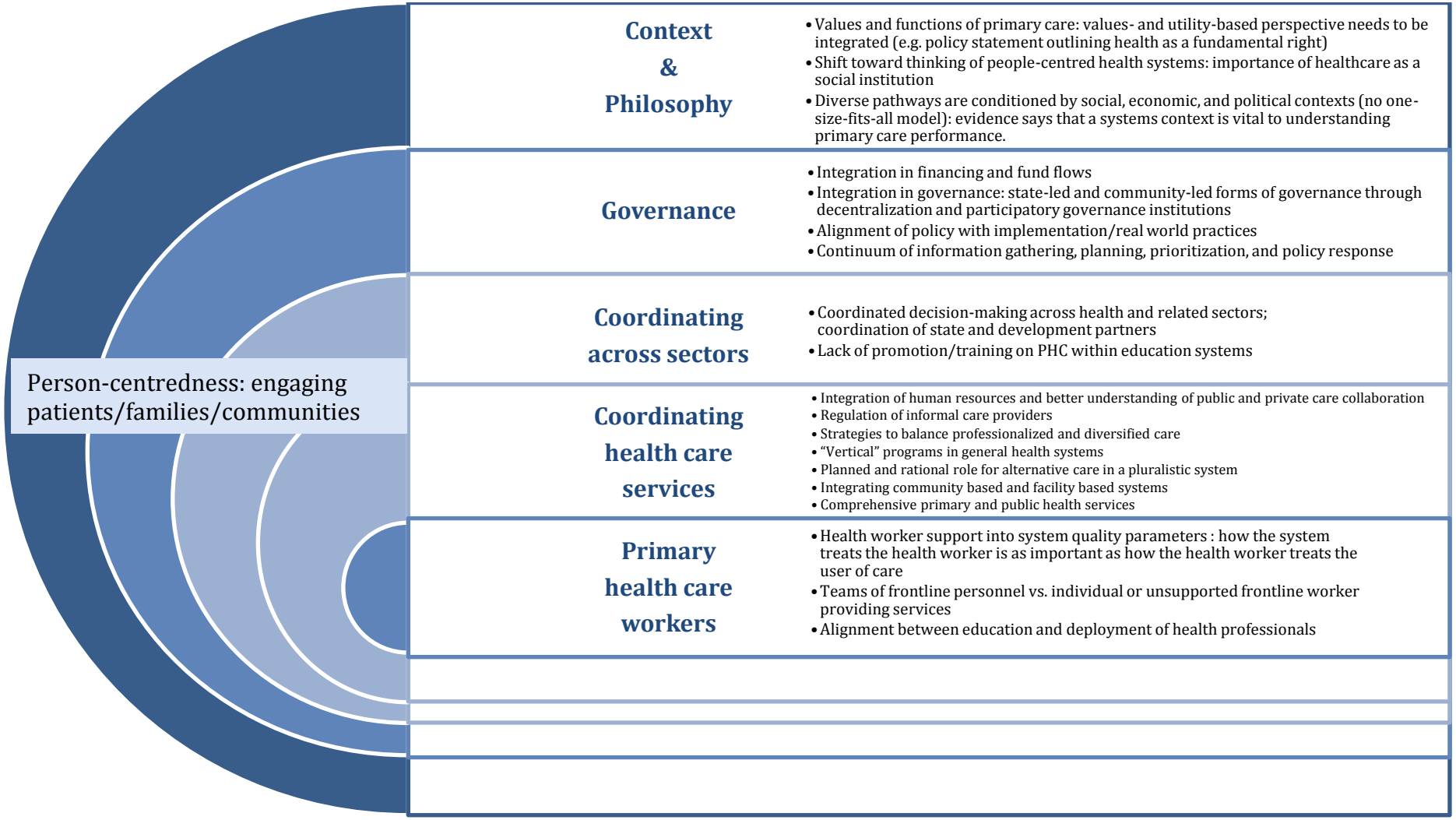
Presenter:
Dr Kabir Sheikh
Senior Research Scientist
Public Health Foundation of India

Despite key successes in primary care service organisation (e.g. essential drug policies, district decentralization of primary care planning), PHC systems in LMICs remain heavily characterised by fragmentation of services delivery, funding flows and supply chains. Integration will thus be a key aspect considered in the PRIMASYS approach.

The performance of primary care systems should be understood in terms of relevant structures and processes explaining services delivery outcomes. Evidence from LMICs and HICs alike has shown that structures (e.g., governance, financing, HR, service organization) and processes (e.g. supervision, information flows) are critical in shaping primary care outcomes.

Integration of services requires consideration of factors across the tiers of the health systems, the connections across other sectors, governance structures in place at the district and national levels, and broader social, economic, and political contexts. See figure 3 for a depiction of these interrelated elements.

Figure 3- Elements to be considered for integration of services



5.1.1 Discussion on challenges to the integration of primary care services

Lead discussant:

Dr Nosa Orobaton
Chief of Party
USAID/Targeted States High Impact Project
Nigeria

- Trustworthiness needs to be taken into consideration to support the credibility of PRIMASYS and its contribution to the integration of primary care services. For the programme to be relevant, PRIMASYS should provide space for stakeholders to act as co-agents in the process.

- Comprehensiveness needs to build in the notion of maturation of health systems

- Grasping the complexity of adaptive health systems involves interactions of agents and the rules that govern interactions

- Effectiveness of primary care systems to mitigate overtreatment and over-diagnosis should be assessed

- Methods pertaining to integration of healthcare services remain a challenge: how do we define successful integration and from whose perspective (e.g. patient, provider)?

- Importance should be placed to sub-national level primary care, to embrace context-specific variability

- Providers are incentivized by the achievement of particular targets (e.g. performance metrics/indicators), yet there is a need to look at different priorities and not just those pushed by performance-based funds.

5.2 Primary Health Care Performance Initiatives (PHCPI)

Presenter:
Dr Hong Wang
Senior Program Officer
Bill & Melinda Gates Foundation

"Better measurement and knowledge sharing can help meet the needs of people and communities"
Dr Hong Wang

PRIMASYS and the Primary Health Care Performance Initiatives (PHCPI) align with the Gates Foundation's shift from technology development to service delivery. The PHCPI conceptual framework (Figure 1) stresses that beyond inputs and outputs, we need to better understand service delivery process (i.e. black box). We thus need good measurement and robust indicators, to assess improvements and learning over time. PHCPI measures are categorised in two categories: 1) **vital signs indicators** to support the identification of problems in the system (25 indicators have been selected thus far), and 2) **diagnostic indicators**, to understand where the problems come from.

There is now a dearth of governance and responsiveness indicators and the PHCPI team is working on developing such metrics. PHCPI also represents a good opportunity to improve data availability and leverage existing survey platforms, as well as create new ones.

Discussion

Lead discussant:
Dr Shannon Barkley
Consultant, Primary Health Care
Services Organization & Clinical Interventions Unit
Services Delivery and Safety Department, WHO

Primary health care seems the clear way to achieve UHC. Measurement, learning and improvement are the three components for PHCPI. The initiative is an opportunity to coordinate available national health systems data and to move away from program-specific data/information.

Countries value primary healthcare but many are still struggling with proximal issues of governance, finance, in addition to the black box of services delivery. Integration of care looks different across contexts, as countries' health systems are at different points in their development.

Clearest overlap between PHCPI and PRIMASYS is probably the cross-talk between countries. The two initiatives are complementary: while PHCPI focuses on quantitative data, PRIMASYS is implementing a mixed methods approach to understand how PHC is organized, what is the relationship between players, and what are the mechanisms making it work.

Challenges:

- How do we ensure that metrics are integrated at the front line?
- What is the best way to move from measurement to improvement?

5.3 WHO global strategy on people-centred integrated health services

Presenter:
Dr Ed Kelley
Director
Department of Service Delivery and Safety, SDS
WHO

The health systems challenges we face are many-fold, and decision makers face new challenges around greater citizen expectations, double-burden of disease, need for cost efficiency and accountability, as well as system constraints including lack of community empowerment and engagement, sub-optimal health workforce, limited intersectoral action and service fragmentation.

Performance and evolving improvement in care integration is difficult to measure and involve many context-specific conditions. Furthermore, the number of internationally successful quality improvement programs is very low.

The new WHO global strategy on people-centred integrated health services provides an opportunity to intersect with other sectors (e.g. social assistance, sanitation) to make the most of social intervention/prescriptions, for instance on disability or housing.

WHO/SDS will launch a Web platform in the near future to collect experiences and evidence on improved performance.

Bearing in mind that “one size does not fit all”, PRIMASYS should provide adequate flexibility for countries to emphasize certain context-specific aspects. In addition, stakeholders involved in the PRIMASYS and PHCPI initiatives should think about the complementarity vis-à-vis the WHO Global Strategy.

Discussion

Lead discussant:
Dr Yongyuth Pongsupap
Senior Expert
National Health Security Office
Thailand

Challenges:

- Moving from the WHO global strategy on people-centred integrated health services to recommendations/options for action for WHO Member States that are relevant for countries
- Need to disentangle integration vs. people-centeredness of care (e.g. a system that thrives towards being centred on people but does not capture the integrated aspect)
- Different interpretation and risk of misinterpretations of "people-centred care"
- Challenge of defining and measuring "integration" and moving towards evidence-based integration (e.g. need for case studies on integrated services)
- Integration should not be considered an end in itself.

5.4 Measuring quality and responsiveness of primary care

Presenter:
Professor Margaret E. Kruk
Associate Professor of Global Health
Department of Global Health and Population
Harvard T.H. Chan School of Public Health

Patient-centeredness is a fundamental necessity for the support of any health initiative, especially UHC. Three questions really drive the reflection on this matter:

- What do people want?
- What do people do?
- How do people experience care?

These questions are necessary form the onset, and should not be considered only once a certain level of care has been achieved. People are active agents of their own healthcare, not passive/beneficiaries and services have to meet expectations to be used. It is crucial to

understand the actual use of a system by patients, as use, non-use and bypassing are important signals of primary care performance.

Global health often pushes coverage, but there is also a need to emphasise good quality as well, as quality deficits undermine trust in PHC and UHC. For instance, a recent survey of HIV+ women from Mozambique and Ethiopia stressed that the most important element in health services utilisation was respectful and pleasant care provided by the care-giver. Integration of services was also identified as an important determinant, as women also wanted non-HIV services to be available at the time of visit. We also need to learn from what patients don't want, which at time can be at odds with issues promoted by policymakers. There is also a need to measure health worker performance/productivity and tackle the issues of mistrust in the health system/clinics.

Recommendations for PRIMASYS:

- Avoid verticalizing primary care: measure PHC and its links to the rest of health system and UHC
- Emphasize on-the-ground performance (*de jure*), not paper policies (*de facto*)
- Tackle cherished notions: referral systems, community health workers, primary care obstetrics
- Think about resilience to health shocks—the new normal – and environmental factors (e.g., flood): need to think about health systems as adaptable entities
- Focus on indicators that lead to action: move from description to assessment, comparison, analysis
- Build usability and opportunities for uptake from the beginning (policy makers, managers) and integrate dissemination/KT efforts from the onset.

Discussion

Lead discussant:
Dr Rajani Ved
Senior Advisor
National Health Systems Resource Centre
& Chair, Task Force on Primary Health Care
Ministry of Health and Family Welfare
Government of India

- "What do people want?" is a question that does not get asked often enough, as research and global health programs are more focused on what policymakers/donors want.

- Measuring bypassers is of the essence and overcrowding at secondary and tertiary centres can be an important indicator: is primary care serving a gatekeeper function?
- Need more research on task allocation to health workers
- Quality improvement should be an iterative process and we need "dialogues over data"
- We need to take stock of lessons in quality of care improvement (e.g. grey literature, NGO reports): what do people consider good technical and interpersonal quality?
- Need to focus on consumer education as health system solutions cannot answer to everything
- How do we understand patient preferences and meet them? Are they always appropriate? Should we be thinking about limits for patient preferences?
- How can we overcome the burden of information asymmetry?

6. Audience

PRIMASYS is likely to span a broad audience of people interested in understanding the underpinnings of primary care systems in various LMIC-settings. Specific products are being developed for the different audiences. These are outlined below.

Primary audience

1) Hands-on Case studies are targeting:

- Programme managers and stakeholders wishing to leverage PHC for their work
  For instance, development agencies/donors wishing to better integrate disease-specific programs (e.g. malaria/nutrition/HIV) in PHC service delivery.

2) Cross country analyses are targeting:

- Stakeholders wishing to improve PHC performance
  Constituency of policymakers, researchers, global/national/sub-national decision-makers, and donors.

Secondary audience

Actors who can support transformative action based on PRIMASYS findings: practitioners/healthcare workers embedded in primary care systems, national and international professional associations, and users of primary care services.

Deliverables

The Experts recommended to plan a special issue in a journal, to disseminate and make the most of the data collected in the 20 countries and to highlight the lessons learned (e.g. synthetic papers).

Country selection

Experts underlined the following issues to take into consideration while selecting the country teams:

- Geographic diversity: maximizing diversity so that we obtain some ability to compare/contrast
- Capacity of health systems researchers/HPSR skillset
- Income status (e.g. middle-income countries also face large burdens)
- Land area is significant: different tasks in front of countries with small land area vs. larger ones
- Burden of disease
- Archetypal states (e.g. states can fall into certain groups with commonalities
- Regions that have been pushing for change
- Stage of PHC system/reform, i.e. different levels of maturity in reform

SECTION 2: STRATEGY FOR CONDUCT OF THE CASE STUDIES AT COUNTRY LEVEL

1. PRIMASYS conceptual framework

i) The systems lens: an integrative perspective

The majority of research attempting to assess or evaluate primary care in low- and middle-income countries (LMICs) has focused on measurements of service performance at the frontlines, and health outcomes. This research has value to the extent of acknowledging the shortcomings and successes of primary care in different settings, but does little to help us to understand the systemic causes and processes that underpin and explain these surface phenomena. What is needed to advance the reform agenda, both in terms of research and action, is an approach that integrates primary care in the broader context of health systems.

A "systems" lens highlights the interconnected nature of different functional elements of primary care systems, with each other, and also with processes and conditions that are external to the conventional boundaries of the health care sector. Primary care systems may be understood to encompass the organizations, resources, procedures, norms and the efforts and time of people that collectively function towards delivering services at the first point of care, and serving the aims of better health and equity in a society.

The systems lens also suggests that the performance of primary care systems cannot be viewed merely in terms of its eventual outputs and outcomes, but must also be understood in terms of related and underlying structures and processes that explain these outcomes. While this remains an under-researched area, there is ample evidence from high and low-income countries alike to indicate that structural elements of a primary care system and key processes are critical in shaping its outcomes.

The Kringos "meta-framework" outlines broad categories of elements that collectively go towards describing primary care systems (Kringos et al. 2010). The dynamic interlinkages between these different elements as they contribute towards the successes and failures of primary care systems vary, and are poorly understood in many country settings (Figure 4).

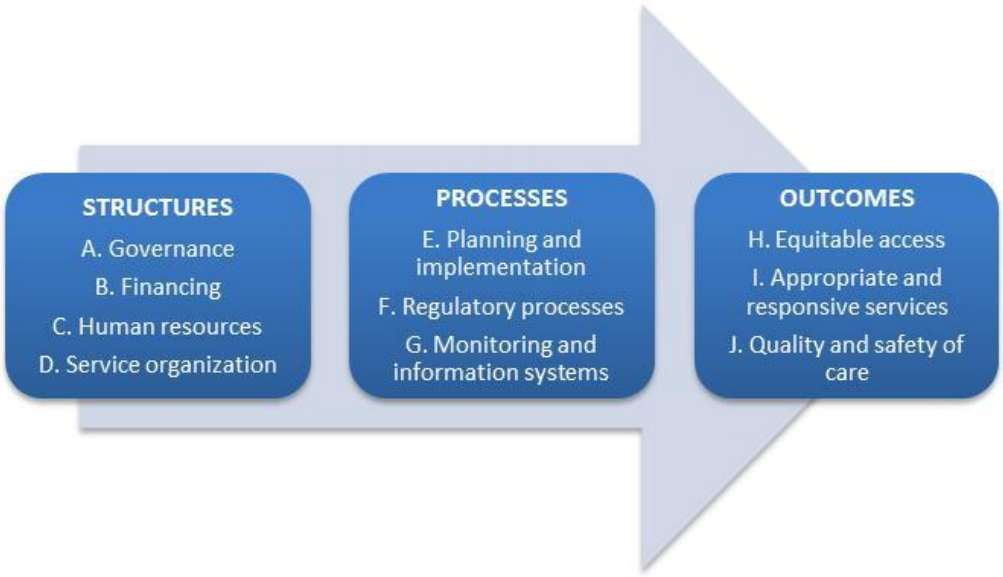


Figure 4- PRIMASYS framework of structure, processes and outcomes of primary care systems **(adapted from Kringos et al. 2010)**

Indeed the proximate structures that contextualize and condition the nature and availability of primary care services represent different parts of the broader system into which primary care must be integrated for it to function optimally. (Conversely many of the failures of primary care services are attributable to problems in integration within the system).

Further, as a number of experts have highlighted (Rohde et al 2008, Fracolli et al. 2014, PHCPI 2015), there is no one-size fits all model of a country-level primary care system, and countries have implemented diverse models, adapted to and conditioned by their respective social, economic and political contexts. Hence, while a higher-level explanatory framework (such as in Figure 1) can help to understand discrete elements of primary care systems, the specific pathways or "mechanisms" of how primary care systems operate and perform are often poorly understood, and need to be identified locally, through context-sensitive, empirical enquiry (Pawson & Tilley 2004).

The PRIMASYS approach hence applies a blended approach of fixed and flexible (contextually determined) types of enquiry.

ii) Primary care systems: elements of enquiry

As stated previously, the Kringos et al. (2010) framework of structures, processes and outcomes provides a simple framework that encompasses the multiple component elements that make up primary care systems, and represents a taxonomy that is broadly aligned with, or builds on many of the alternative logic models and frameworks in circulation. The elements that constitute primary care systems can be organized within this broad classification, with the accepted limitation that there are overlaps between the three categories, and likely potential differences of perspective can arise around how one might classify the elements. The following paragraphs chart and explain the different elements within the framework and, within each element, the specific phenomena and themes that reflect the performance of primary care systems, and warrant investigation in order to achieve a robust understanding of country primary care systems.

While social and environmental determinants of health have a crucial bearing on the performance of primary care systems, our scope of enquiry includes aspects of health systems governance that address these determinants, while excluding independent enquiry on these factors.

Structures refer to the relatively unchanging elements of primary systems – institutional, infrastructural and economic that shape and condition the delivery of effective services. Structural elements are broadly classified into Governance, Financing, Human Resources, and Service organization.

A. Key aspects of *Health System Governance*, as a high level function, that can be recognized as being immediately relevant to the performance of primary care systems
B. Arrangements and systems for *Financing* health, and improving financial flows in the health sector that are relevant for primary care systems
C. Aspects of the availability of *Human Resources for Health* and health worker education and support systems that directly influence the performance of primary care systems
D. *Service Organization* refers to the organizational arrangements that can facilitate the efficient, equitable and appropriate delivery of integrated, high quality primary care services.

Integration of structural elements can be of different types and have many dimensions, as illustrated in Figure5.

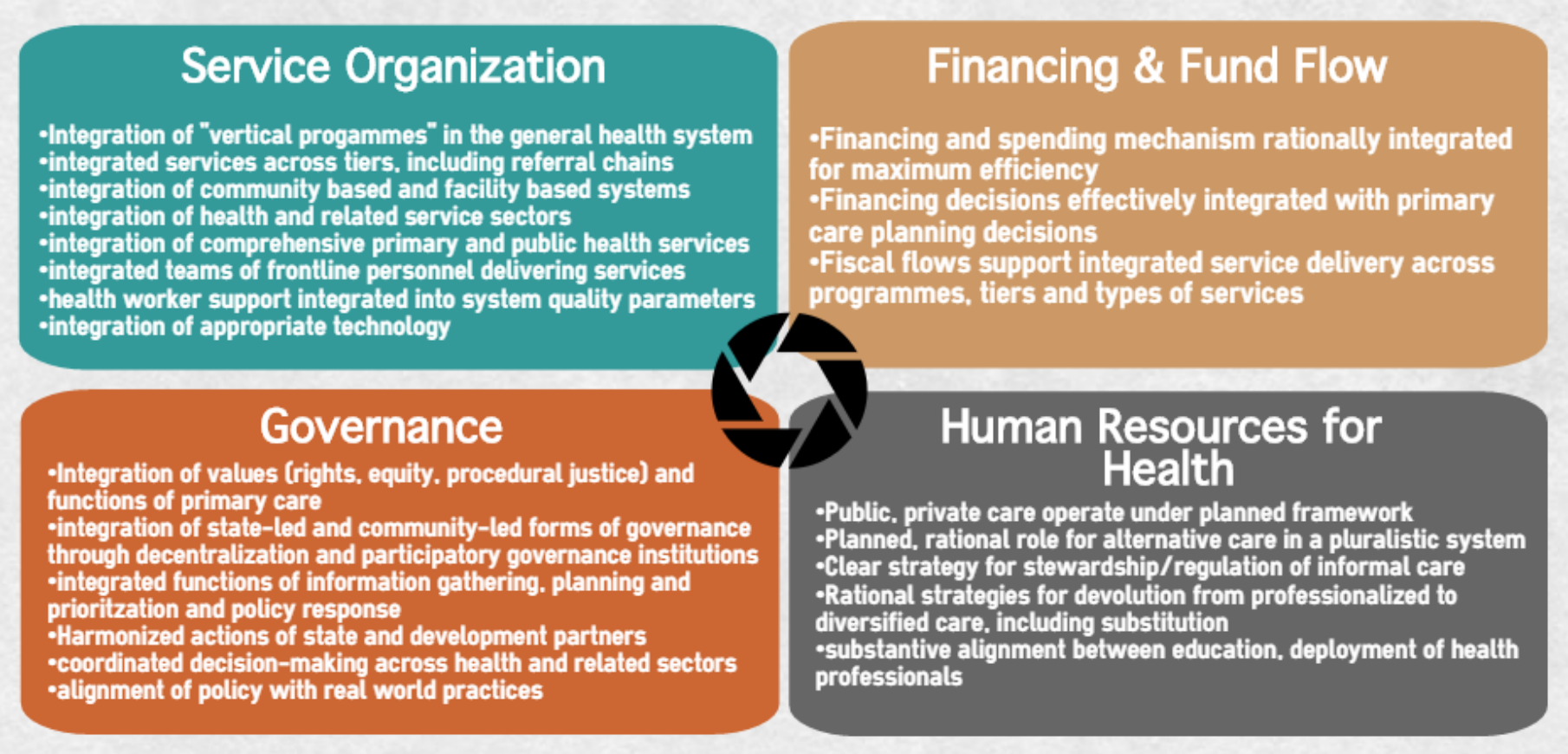


Figure 5- Primary care: dimensions of system integration

Processes refer to the dynamic phenomena and events that occur in planning, regulating implementing and monitoring primary care systems, and influence their ultimate performance.

E. It is widely recognized that in the health systems of many low and middle-income countries, de facto conditions frequently do not follow de jure governance arrangements. Wherever possible, it is important to ascertain what actually happens (rather than what is expected to happen) in the *Planning and Implementation* of primary care services
F. *Regulatory Processes* reflect the government's ability to ensure the conditions for fair competition and high quality in markets for primary health care. While critically important to curb distortions associated with market failures in mixed health systems, such knowledge is typically not easy to objectively ascertain in a short span of time, and is better understood through key informants, and by tracking existing research.
G. *Monitoring and Information Systems* are crucial factors in ensuring internal accountability and the alignment of publicly delivered primary care services with their intended functions.

Health systems **Outcomes**, as distinct from "health outcomes" (beyond the scope of these case studies) are manifestations of the performance of primary care systems at the frontlines. Key outcome categories include equitable access to primary care services at scale, the appropriateness and responsiveness of those services to people's needs, and the quality and safety of the services that people ultimately receive.

H. The first and most apparent outcome of a successful country primary care system is *Equitable Access at Scale*, of primary care services.
I. *Appropriate, People-centered and Responsive Care*: care services must be organized in a manner that are responsive to the long term needs of users, and reflect the role of primary care services as social and community-embedded institutions
J. *Quality and Safety* of care is of paramount importance and finds reflection equally in the perceptions of users, and in adherence to the technical parameters that guide standard care practices.

2. Approach for conducting country case studies

i) Principles guiding a national assessment of primary care systems

According to Bennett and Peters (2015), national health systems assessments (HSA) should be "*relevant*, addressing the purpose for which it was designed; *trustworthy* in terms of being of high quality, rigorous and credible in the eyes of stakeholders; and *coherent*, considering the health system as a meaningful whole with linkages across system components."

Relevance implies the fidelity of the assessment to its ultimate purpose and intention, which are, in this instance to summarize knowledge on the structure processes and outcomes of primary care systems, elaborate specific pathways of success and failure and promote learning. While exploration of a fixed set of core elements is warranted across all cases, it is equally important for the enquiry to be partially customized to the country in question, and for specific pathways of change to be delineated empirically (Pawson and Tilley 2004). This calls for mixed methods in data collection, and an approach to analysis and interpretation that embraced complex causality.

Trustworthiness implies quality, rigour and credibility in the eyes of stakeholders, which is a critical factor in ensuring buy-in and facilitating learning from the process. Quality and rigour are partly reflected in the quality and reliability of the secondary data that are available for national health systems assessments of this nature. Frequently such data are unreliable, and judicious decisions, involving deliberations and triangulation with country key informants, must be made around how (and whether) to use and interpret data that may be dubious. All primary data collection contributing to the assessment must observe standard norms of rigour and quality in health policy and systems research (Sheikh et al. 2014). Likewise, standard research ethics norms should be upheld, and ethics permissions obtained. It is also vital that case study findings are plausible to stakeholders in the country in which the case study is undertaken. Engaging in-country key informants continuously before and through the research facilitates such credibility (Erlandson et al. 1993)

The criterion of **coherence** requires that the health system be regarded as a meaningful whole with linkages across system components. Hence the relationships between the components or

"moving parts" of the PRIMASYS framework (Figure 1, adapted from Kringos et al. 2010) cannot be expected to be uniform, and require empirical research to understand them.

ii) Overview of approach and methodology for country case studies

In keeping with advances in Health Policy and Systems Research (HPSR) (Lehmann and Gilson 2014, Sheikh et al. 2014) the methodology for these case studies integrates activities and assigns roles to the research team, that go beyond the tasks of simple data collection and analysis, and extend to engaging varied stakeholders with a view to contextualizing the research and its outputs, and promoting learning and reflection. The aims of undertaking these case studies may be defined as follows:

- To summarize key aspects of the structures, processes and outcomes of the country's primary care systems that reflect their performance
- To elaborate specific "pathways" that have contributed to notable successes and/or failures in the country's primary care systems
- To promote learning among relevant stakeholders in order to motivate policy change

Each case study will involve three phases of research.

Phase 1 is the phases of preliminary enquiry, in which basic information will be collated on the health and health systems profile of the country (or state/province) in question. Discussions with key informants at this stage will also yield basic information on how primary care services are organized and on the history and context of PHC reforms in the country, contributing to the identification of additional questions around pathways of change that are of specific relevance to the country, and that will be explored in Phase 2.

In **Phase 2** or the main phase, core elements of enquiry on primary care systems that are common to all country case studies will be investigated. This phase will also consist of enquiry on specific questions or pathways of change, which are specific to the country in question. These questions will be identified during Phase 1. This phase will go further to identify custom characteristics specific to the countries being studied in addition to commonalities across countries.

A combination of qualitative and quantitative methodologies for data collection and analysis will be employed, applying principles of ethics and rigour relevant for HPSR.

Phase	Data collection	Analytic approach	Outputs
1. Preliminary	• Structured discussions with Key Informants • Review of relevant secondary sources	• Narrative synthesis and collation	• Basic information on health and health systems profile of country • Profile of organization of primary care services • Brief narrative report on history and context of PHC reforms • Identification of questions around country specific pathways of change for phase 2
2. Main phase (25 fixed elements to identify commonalities and 10 flexible elements to identify custom characteristics)	• Interviews with health system actors • Review of secondary sources	• Thematic synthesis of qualitative data • Measurement of key structures, processes, and outcomes	• Brief summary reports of 25 fixed elements of enquiry pertaining to primary care systems • Brief summary reports of 10 flexible elements pertaining to primary care systems

iii) Approach to cross-case analysis and learning

Cross case analysis is a multi-layered process, and should be differentiated across the types of assessment that have been undertaken.

- *Numerical results*

Numerical indicators are chosen on the basis of universality in interpretation and ease of measurement, making it appropriate to present comparative tabulations between individual indicators across countries. Aggregate country scores will not be created.

- *Qualitative results*

Descriptive data from qualitative analysis will be directly compared across country settings, and can illuminate how individual structures, processes or elements operate differently in different settings. In the case of more subjective results that are not directly comparable or generalizable, cross case analysis should be a dynamic process involving insight and creativity of the research teams. Progress in analysis and learning in such cases, occurs through the process of dialogue, rather than through the solitary perusal of data (Flyvbjerg 2001), and can be enabled through engagement between research teams from different countries. Colleagues can gain insight and resonance about their own country settings, from explanations of primary care system performance emerging from a different country setting. Principles of analytical generalizability in HPSR indicate that comparison should be "grounded in a process of abstracting from the specifics of one case to ideas that encompass several cases." Teams may engage with each other to derive explanations that are rich in their specificity, but sufficiently general to find resonance in different contexts (Gilson 2012).

The case study template and guidance for country teams in carrying out the case studies can be found in the attached document. This also includes a list of indicators and elements of inquiry to use to build these case studies. Country teams will be provided with the template, the case study methodology and approach, as well as technical assistance from the Alliance Secretariat throughout the duration of the project.

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Annex 1. Meeting Agenda

Day 1 22 July 2015	Session Content	Speakers
08:45 – 09:00	Welcoming coffee	
09:00 – 09:30	Opening remarks Objectives of the expert consultation Introduction of participants	Abdul Ghaffar Hong Wang Etienne Langlois All
	SESSION 1 – OVERVIEW OF PRIMARY CARE ORGANISATION AND PERFORMANCE	*Chair:* Abdul Ghaffar
09:30 – 10:15	***Primary care systems in LMICs: the challenge of integrating healthcare delivery systems*** Discussion	*Presenter:* Kabir Sheikh *Discussant:* Nosa Orobaton
10:15 - 11:00	Primary ***Health*** Care Performance ***Initiative (PHCPI)*** Discussion	*Presenter:* Hong Wang *Discussant:* Shannon Barkley
11:00 – 11:15	Coffee break	
	SESSION 2 – COUNTRY EXPERIENCES	*Chair:* Hong Wang
11:15 – 12:00	***Primary care and decentralised health systems: lessons from Thailand and Brazil*** Discussion	*Presenters:* Yongyuth Pongsupap & Airton Stein *Discussant:* Anbrasi Edward
12:00 – 12:45	***Primary care organisation and reforms: experiences of India and Malawi*** Discussion	*Presenters:* Rajani Ved & Humphreys Nsona *Discussant:* Lilian Dudley
12:45 – 14:15	Lunch break	
	SESSION 3 – PRIMARY CARE IN COMPLEX HEALTH SYSTEMS	*Chair:* Nosa Orobaton
14:15 – 15:00	***Towards integrated primary care systems*** Discussion	*Presenter:* Ed Kelley *Discussant:* Yongyuth Pongsupap
15:00 – 15:45	***Primary care in LMICs: data sources and key indicators*** Discussion	*Presenter:* Margaret Kruk *Discussant:* Rajani Ved
15:45 – 16:00	Coffee break	
16:00 – 16:45	***Overview of PRIMASYS framework*** Discussion	*Presenter:* Kabir Sheikh *Discussant:* Airton Stein

16:45 – 17:00	**Wrap-up Day 1**	Etienne Langlois
Day 2 **23 July 2015**	**Session Content**	**Speakers**
08:45 – 09:00	Welcoming coffee	
09:00 – 09:15	Summary of Day 1	Etienne Langlois
	SESSION 4 – LEARNING FROM PRIMARY CARE CASE STUDIES	*Chair:* Shamsuzzoha Babar Syed
09:15 – 10:45	***Methodology to develop case studies of primary care systems in LMICs & PRIMASYS data collection template*** Discussion	*Presenter:* Kabir Sheikh *Discussant:* Margaret Kruk
10:45 – 11:00	Coffee break	
11:00 – 11:45	***Strategy to select the country case studies*** Discussion	Abdul Ghaffar *Discussant:* Hong Wang
11:45 – 12:45	***Drawing cross-cutting lessons informing the performance of primary care systems*** Discussion	*Presenter:* Kabir Sheikh *Discussant:* Shannon Barkley
12:45 – 14:00	Lunch break	
	SESSION 5 – WAY FORWARD	*Chair:* Abdul Ghaffar
14:00 – 15:00	***PRIMASYS methodology and implementation*** Discussion	All
15:00 – 15:45	**Next steps**	Etienne Langlois
15:45 – 16:00	**Closing**	Abdul Ghaffar Hong Wang

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