RESEARCH BRIEF

# EXEMPLARS IN PRIMARY HEALTH CARE: LESSONS FROM FIVE COUNTRIES


## EXECUTIVE SUMMARY

The Primary Health Care (PHC) Exemplars study identified five countries—Zambia, Ghana, Rwanda, Bangladesh, and Peru—whose PHC systems have performed unusually well over the past 20 years relative to their total health spending. In our research, we asked: What accounts for this success? How have these countries reformed their health systems to improve efficiency, equity, and quality? Finally, what lessons can we learn from their work?

Our study revealed three main categories, or pathways, for reforming PHC systems:

1. Spending enough, and spending well, on PHC
2. Implementing systems for performance management, accountability, and community engagement
3. Expanded access to care and facility readiness, boosting utilization rates

Crucially, these pathways are interrelated and complementary. Successful approaches to PHC system reform include aspects of all three.

We also found that health system improvement does not happen overnight. Over time, all five Exemplar countries invested in their PHC systems in roughly the same sequence: first, they built foundations of governance and financing; then, they expanded access to care; and most recently, they refined and built on earlier reforms, expanding their scope and improving their quality.

This study identified the following important lessons for policymakers:

- Primary health care is a long-term commitment.
- Across every pathway, successful PHC reforms are intentionally designed with long-term health system goals —such as efficiency, equity, and quality—in mind.
- PHC depends on adequate, equitable, and consistent funding and robust national processes for strategic planning and resource coordination.
- Processes for performance management and accountability enable data-driven decision making and service delivery improvements at all levels of the health system.
- Reducing financial and geographic barriers to care and ensuring the readiness and availability of services are key to building health systems that are truly equitable.


## Why is PHC Important?

Primary health care is essential health care that's accessible and acceptable to individuals and families in the community, at a cost that the community and the country can afford. PHC is good for people: researchers estimate that high-quality health care – largely PHC – could prevent more than half of excess deaths in low- and middle-income countries each year and could avert as many as 60 million deaths by 2030. It is also good for health systems. For instance, effective PHC systems can reduce health care costs by lowering hospital admissions and rates of emergency department use. Finally, experts believe strengthening PHC is essential to achieving universal health coverage worldwide.

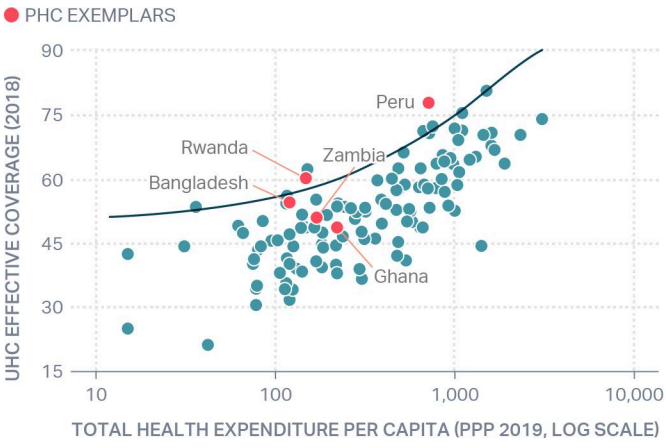
Despite the importance of PHC, rising levels of debt and lingering effects of the COVID-19 pandemic have placed additional fiscal constraints on health systems. As countries continue to have fewer financial resources to address a growing number of health challenges, the pressure to provide basic services affordably and well increases.

Increasing PHC system efficiency, equity, and quality—that is, finding ways to provide more and better health care for less—can alleviate some of these burdens even as challenges and constraints remain.

## How did we select the PHC Exemplar countries?

We selected five Exemplar countries that achieved higher levels of effective coverage relative to peers who spent the same amount on health—a proximate measure of system performance that indicates comparative efficiency as well as quality (see Figure 1).

**Figure 1: PHC Exemplars country selection approach**




*Source: IHME*

PHC Exemplar countries also demonstrated strong performance on key indicators for primary health care coverage, health outcomes, and the equitable delivery of high-quality health services. In other words, the reforms they implemented aimed to drive improvements across all three key health system goals of efficiency, equity, and quality.

The Exemplar countries we selected are at different points on the path to PHC efficiency improvement, which makes our research findings relevant to a range of countries.

## Key Findings: Three complementary pathways toward PHC reform

Over the past two decades, all five of the Exemplar countries have implemented a range of different reforms aimed at improving the efficiency, equity, and quality of their PHC systems. Together, these reforms fall into three key categories, or pathways (see Figure 2).

**Figure 2: Three key categories of PHC system reform**

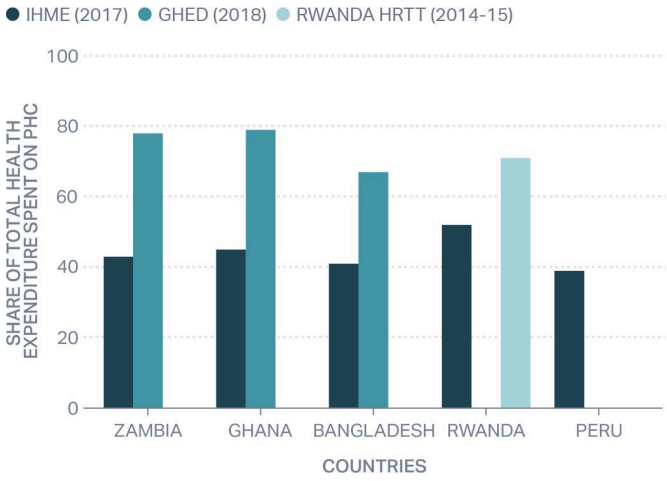

Abbreviations: BGD, Bangladesh; GHA, Ghana; PER, Peru; RWA, Rwanda; ZAM, Zambia.

The pathways represent a set of interrelated processes that work together to produce results.

### PATHWAY 1: SPENDING ENOUGH, AND SPENDING WELL, ON PHC

All five Exemplars countries consistently allocated a substantial percentage of their total health expenditure to PHC (see Figure 3). They also worked to ensure a stable and sufficient flow of funds to the lower levels of the health system that typically deliver PHC. High budget execution rates suggest that Exemplar countries managed and used those resources effectively and efficiently.

**Figure 3: PHC Exemplars allocations to PHC**



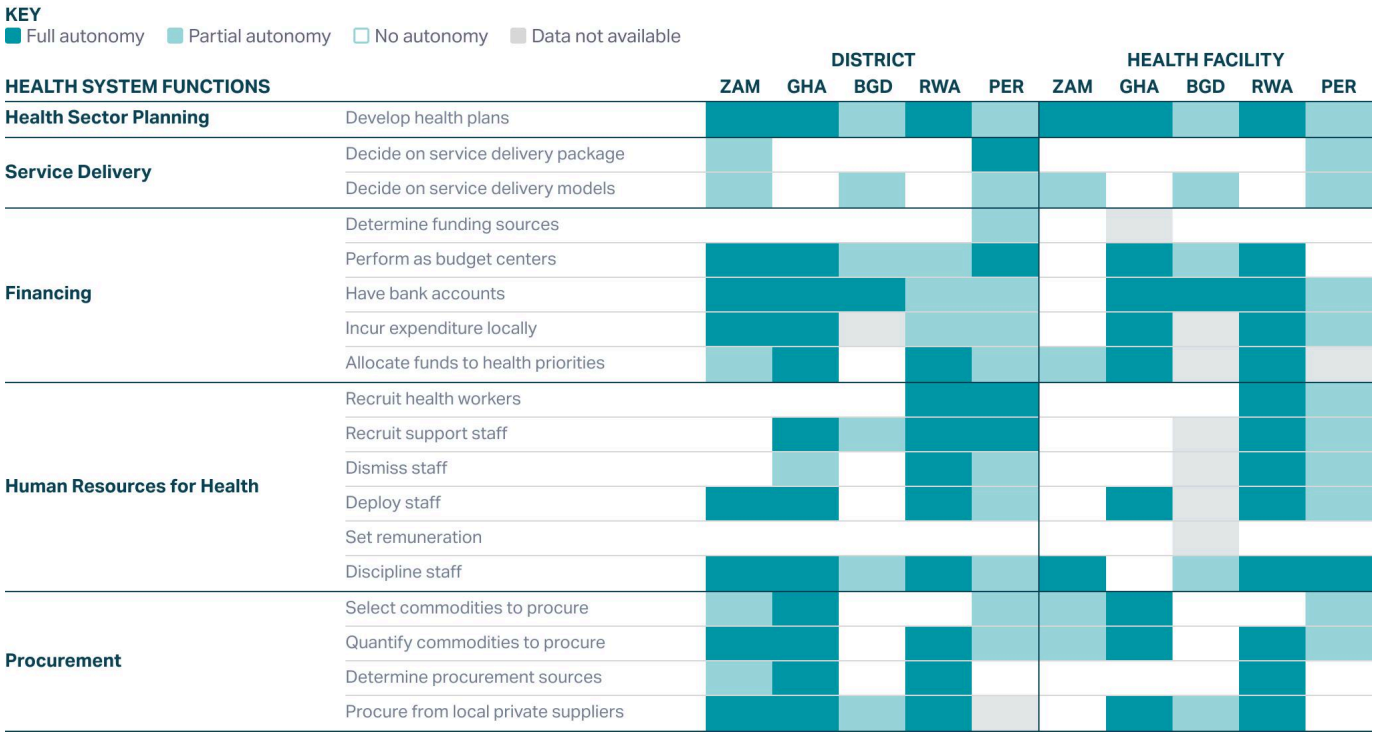

*Source: IHME, GHED, and Rwanda Health Resource Tracking Tool*

Exemplars built priority setting capacity to plan for and utilize PHC resources efficiently, used coordination mechanisms for alignment and accountability, and invested in evidence-informed policies. Most Exemplar countries also delegated some decision-making authority to subnational levels of the health system, including districts and individual health facilities (see Figure 4). This practice empowers districts to identify their own needs and allocate a small percentage of cash resources to meet them, enabling timely and efficient problem-solving (such as buying drugs from private providers in case of stockouts, or hiring support staff when needed) and improving service delivery.

The balance of functions between the central and subnational levels of the health system have been carefully calibrated in PHC Exemplar countries. The following functions generally happen at the central level: resource allocation for health services; establishment of essential service packages; recruitment, training, and deployment of health workers; and procurement. At the subnational levels, officials participate in bottom-up planning processes for district and facility action plans and help shape budget and procurement requests (see Figure 4).

PHC Exemplar countries also took steps to iterate and improve their systems over time, giving stakeholders plenty of opportunities to learn and adapt. For instance, Rwanda's reform process had three phases: the first (2001–2005) focused on geographic and administrative restructuring, the second (2006–2010) focused on enhancing the effectiveness of service delivery, and the third (2011–2015) focused on developing mechanisms for public accountability.

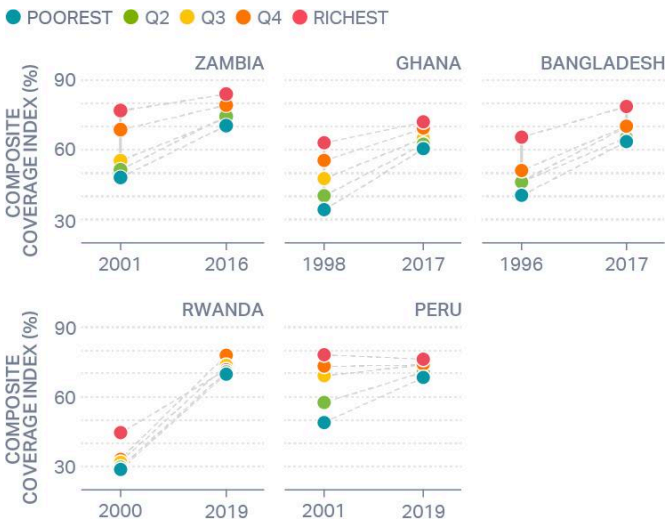
**Figure 4: PHC Exemplar countries' decision-making autonomy across health system functions**




*Source: PHC Exemplars Analysis.* Abbreviations: BGD, Bangladesh; GHA, Ghana; PER, Peru; RWA, Rwanda; ZAM, Zambia.

Most Exemplar countries explicitly pursued equity when allocating resources for PHC. For instance, they adjusted district grants according to need and introduced subsidies and fee exemptions for low-income populations (see Figure 5).

**Figure 5: Improvements to equity in service coverage across wealth quintiles in PHC Exemplar countries over time (years vary)**




*Source: WHO Global Health Observatory*

## PATHWAY 2: IMPLEMENTING SYSTEMS FOR PERFORMANCE MANAGEMENT, ACCOUNTABILITY, AND COMMUNITY ENGAGEMENT

All five Exemplar countries aligned their PHC systems with local needs and priorities by fostering mechanisms to facilitate community input and participation. For example, the countries improved information systems to enable more data sharing, which made engagement with community governance structures and civil society organizations easier. (Findings from our research showed greater digitization, better system interoperability, and more defined processes for data-driven decision making in countries with more health system resources.)

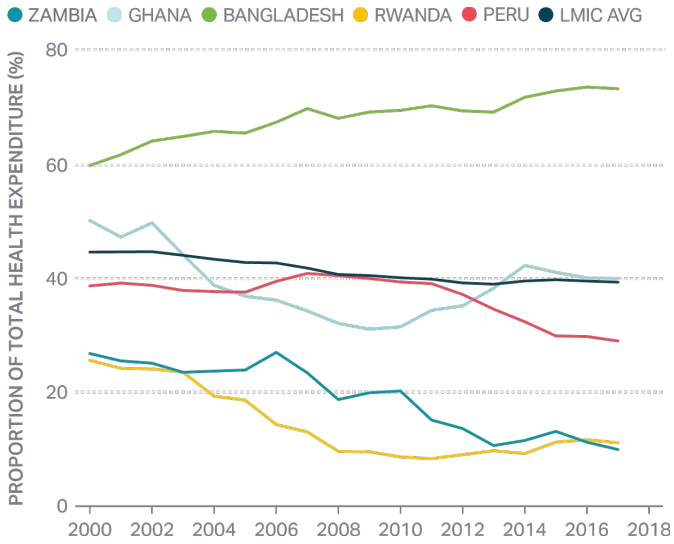
The PHC Exemplar countries also built more formal mechanisms for performance management and accountability. For instance, countries increased the transparency of programmatic reporting, explicitly connected funding and other resources to programmatic achievement, and established dedicated institutions to support these processes.

## PATHWAY 3: IMPROVING ACCESS TO CARE AND FACILITY READINESS, BOOSTING UTILIZATION RATES

All PHC Exemplar countries increased utilization of PHC services by reducing barriers to access. For example, lowering out-of-pocket costs removed some financial barriers to care (see Figure 6). Likewise, building infrastructure for PHC service delivery in or near the communities where people live removed some geographic barriers (see Figure 7).

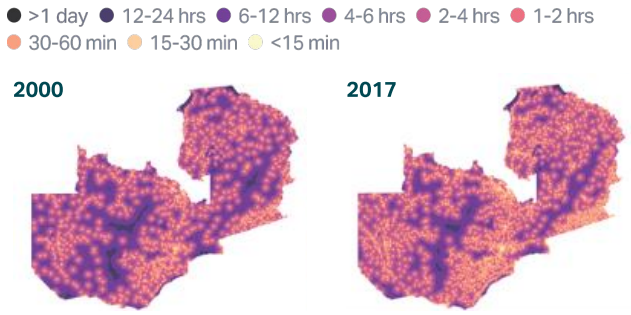
For instance, in 2000, an estimated 21% of children younger than 1 year of age in Zambia lived within a 30-minute walk of a facility that offered routine immunization services, compared with 34% in 2017.

**Figure 6: PHC Exemplars' trends in out-of-pocket expenditure (2000-2017)**




*Source: IHME*

**Figure 7: : Zambia reduced travel time to nearest facility offering routine immunization (2000-2017)**

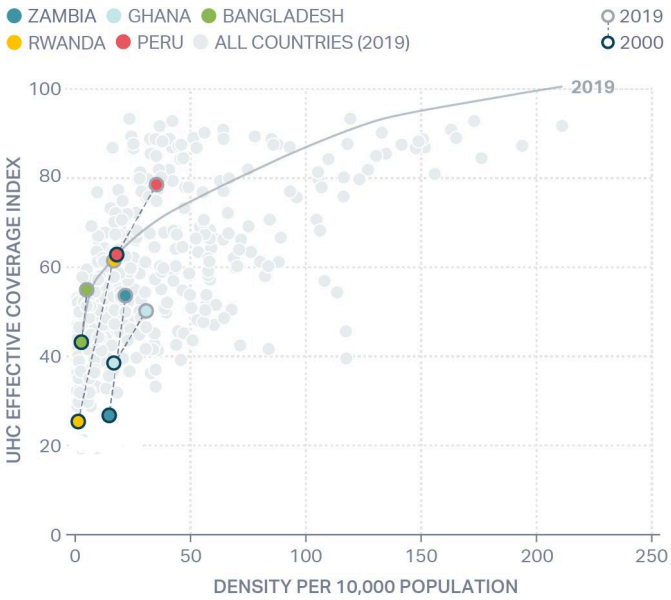



*Source: IHME*

The countries also improved the readiness of PHC facilities to respond to increased demands for health services, such as by ensuring the availability of essential medicines and supplies.

All five PHC Exemplar countries increased their health workforce, particularly community health workers and nurses. Mechanisms to motivate and retain these key workers included workforce formalization (such as pay and training) and other incentives (see Figure 8).

**Figure 8: Changes in service coverage across PHC Exemplar countries given densities of nursing and midwifery personnel (2000–2019)**




Greater density of PHC healthcare worker cadres is associated with increased coverage across PHC services. PHC Exemplar countries took strides to optimize critical HRH between 2000 and 2019, contributing to improvements in service coverage. (Showing all countries 2019 data for reference).

*Source: IHME*

In all five Exemplar countries, increasing the density and distribution of the PHC workforce was associated with increased and improved coverage across PHC services.

Critically, we found that the three pathways do not operate in isolation. They interact with, build on, and complement one another, enabling performance improvements and boosting efficiency and equity.

## How did these changes happen?

The PHC system reform process was an ongoing, iterative process that occurred over two decades in the countries we studied. Though we found a degree of variation among the Exemplar countries, all five made the following investments in their PHC systems in roughly the same order:

1. **Built foundations of governance and financing.** Governance reforms aimed at establishing subnational structures and delegating decision-making authority were a key prerequisite for other major changes, such as increased donor coordination and strategic planning.
2. **Expanded access to care.** This included outreach to bring services closer to communities, the introduction and formalization of community health workers, fee exemptions and subsidies to ensure financial protection for patients, and building and improving health facilities.
3. **Refined and built on earlier reforms, expanding their scope and improving quality.** In countries with more optimized health systems, this included expanded service offerings, evolved payment models, improved use of data for decision making (increasingly digitized), and a focus on improving quality of care.

In addition to these operational details, we looked closely at the political-economic context for the PHC Exemplar country reforms we studied. Findings from this research yielded five additional insights:

- **Policymakers leveraged key opportunities and public interest to implement health system reforms**. For instance, Ghana's National Health Insurance Scheme was part of a political platform introduced in response to citizen demand.
- **Influential stakeholder groups drove other reforms.** In Bangladesh, civil society organization BRAC advocated for new community-based service delivery models.
- **Durable reforms were often supported by underlying elements,** such as institutional capacity, feasibility for scale, population entitlements, or the law.
- **Institutional and bureaucratic commitments to implementing health system reforms made them more successful.** For instance, many Exemplar countries established semiautonomous agencies focused explicitly on the work of implementation, such as the Ghana Health Service, the Rwanda Biomedical Center, and Zambia's Central Board of Health.
- **Exemplar systems evolved in response to changing circumstances.** This responsivity enabled countries to sustain their efforts over time. For example, policymakers ultimately abolished Zambia's Central Board of Health due to changing political circumstances, but they assigned some of its capacities (such as establishing and managing routine monitoring and evaluation) to other formal structures.

In general, and perhaps most important, the Exemplar countries we studied had the capacity and the political will needed to implement the systemic reforms they designed. This was key to their success.

PHC Exemplars research shows that it is possible for countries to improve the efficiency, equity, and performance of their primary health care systems even in the face of resource constraints. It also shows that the three goals are not mutually exclusive. In fact, it is possible to improve health system performance and efficiency overall while still targeting interventions to meet the specific needs of vulnerable groups.

## Research partners

A consortium of research partners led the PHC Exemplar Study. The cross-country study is co-led by the London School of Hygiene & Tropical Medicine and the KEMRI-Wellcome Trust Research Programme. It includes researchers from International Centre for Diarrhoeal Disease Research in Bangladesh (iccdr,b), the University of Ghana, Universidad de Peruana Cayetano Heredia in Peru, the University of Rwanda, and the University of Zambia.