WMA STATEMENT ON PRIMARY HEALTH CARE

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PREAMBLE

Primary health care (PHC) is a key part of any health system, due to its wide coverage and distribution, its accessibility and its ability to solve the health problems of the population. For this reason, it is a fundamental element for social cohesion that corrects health inequalities between people and territories, guaranteeing equity in health care, and energizing close, accessible, and efficient health care that adapts to health changes.

PHC must enhance its positive aspects: high quality, safe, comprehensive, integrated, accessible, available, and affordable for everyone and everywhere, provided with compassion, respect, and dignity to solve the majority of the health problems of the population.

The PHC approach is foundational to achieving our shared global goals in Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (SDGs).

PHC comprises a broad range of personal medical care, including preventive, diagnostic, palliative, therapeutic, curative, counseling and rehabilitative care, over time. It is not an exclusive disease-centered approach, but a person-centered approach. Furthermore, PHC is multi-sectoral health care and aims to empower individuals, families and communities to take an active role in improving their health. PHC should be provided in a manner that is accessible, comprehensive and led by a physician to ensure appropriate and high-quality care. It offers the full spectrum of essential health services across all ages.

PHC usually is the first contact of the people with the health care system. It can address the majority of health needs of the population through comprehensive and integrated services in a continuous and longitudinal way.

PHC offers a comprehensive care of essential health services across all ages.

Strong PHC is vital for efficient, cost-effective, equitable, appropriate and sustainable health care systems. A significant portion of health needs can be addressed at the primary care level, redistributing the workload and relieving strained emergency systems as well as secondary or tertiary health care. The provision of longitudinal care and a trustful patient-primary physician relationship will reduce parallel care demand and unnecessary referrals. Continuity of care has also been shown to reduce mortality, acute hospitalizations and out-of-hours care.

PHC contributes to the prevention, early detection, risk-factor identification and mitigation, and timely response to infectious, communicable diseases and noncommunicable diseases outbreaks, and optimal adherence to treatments and rehabilitation.

Robust PHC can enhance the responsiveness of health systems by adapting to the existing or future health needs of the population, contributing to a socially accountable care by actively engaging and mobilising communities, and allowing patients access to participatory and multidisciplinary care.

PHC is in a unique position to address the social determinants of health inequalities and to enhance individual physical and mental health and social well-being.

Specialist education in general practice/family medicine has developed differently in different regions. In some countries the specialty is as comprehensive and reputed as other specialties.

Where case management or coordination might limit access to appropriate medical care, patients should have the freedom to see a physician appropriate for the services they need, regardless of specialty. Above all, the best interests of the patient must be paramount.

PHC must consider the new challenges that health systems are facing, such as the high prevalence of chronic diseases, the risks of epidemics and pandemics, the environmental impact and climate change on health or the problem of antimicrobial resistance, as the main threats to health in the coming years, as indicated by the World Health Organization, prioritizing PHC actions and acting on these risks to respond to the main global health challenges.

RECOMMENDATIONS

The World Medical Association recommends that national governments/national health authorities:

1. Strengthen PHC within health systems and plan and ensure adequate financial resources and equipment provision in PHC facilities, including a sufficient, well-trained supply of primary care physicians–family physicians, general internists, general pediatricians, and obstetricians/gynecologists – to meet the nation's current and projected demand for health care services.

2. Promote PHC with adequate human and material resources and means to make it more decisive, effective, efficient and sustainable.

3. Ensure responsiveness to the health needs of the population through adaptation of health systems and enable community participation through adaptation of PHC systems to the population health needs.

4. Establish functional referral systems and mechanisms that foster the coordination and integration of care across different levels (primary, secondary, tertiary) and the collaboration of PHC physicians with other medical specialists ensuring care continuity.

5. Ensure workforce planning and adequate size of the PHC workforce by providing decent working conditions for the PHC workforce, including the improvement of working conditions and of remuneration, use of recruitment and retention strategies that take special consideration of hard-to-reach geographic areas and isolated socio-demographic groups and prioritize training of sufficient medical and paramedical personnel to ensure adequate future staffing in PHC.

6. Develop other administrative support mechanisms to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

7. Promote PHC as close health care connected to people as a basis for positive knowledge.

The World Medical Association recommends that its constituent members as well as medical professionals:

8. Advocate for a sustainable PHC system that delivers integrated and comprehensive services inclusive of promotive, preventive, curative, rehabilitative and palliative care.

9. Increase the resolution capacity and reduce the bureaucratic burden of the PHC.

10. Reaffirm the need for high quality PHC services through the development and use of clinical guidelines, standardized training and accreditation of the PHC workforce.

11. Develop professional autonomy and involvement in the management of PHC physicians.

12. Work with national governments and academia to optimize the higher and postgraduate education of the PHC personnel. Such actions can include:

    - Develop and expand medical education programs to educate primary care physicians in increasing numbers.
    - Promote training opportunities for medical graduates to fulfill the estimated demand of the PHC workforce, as well as primary care experiences for all students that feature increasing levels of student responsibility and use of ambulatory and community-based settings.
    - Make available Continuous Medical Education that considers the particular needs of the PHC workforce.
    - Advocate for the establishment of a structured specialized education for general practitioners and family medicine doctors or other specialized education programmes for physicians working in PHC and give it prestige and make it attractive.

13. Ensure that in a context of violence or in a military setting, PHC can also be delivered according to the needs of the population, ethically and with high quality.

14. Provide students career counseling related to the choice of a primary care specialty and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

15. Enhance the visibility of primary care faculty members and encourage positive attitudes toward primary care among all faculty members.

16. Encourage efforts to align the representation of PHC physicians with specialized/~~-~~hospital-based physicians

in political decision making and national medical organizations and to reduce inappropriate remuneration imbalances between physicians with comparable training in different levels of care.

17. Advocate for PHC systems that involve patients and communities and can adapt and respond to specific settings and population health needs.

18. Support the appropriate use of technologies, information systems, digital devices and big data tools that foster and improve PHC services.

19. Support research on health service delivery in the primary care setting, promoting the research culture.

20. Fulfill the international commitment of States to strengthen PHC as an essential step towards achieving universal health coverage, building sustainable PHC and towards achieving the highest attainable standard of health (Astana Declaration).

21. To promote, through PHC a more accessible, close and humane medicine, centered in the person, and prioritizing the needs and interest of patients.