An unfinished agenda

insights from seven country case studies on strengthening primary health care in the Western Pacific Region

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An unfinished agenda: insights from seven country case studies on strengthening primary health care in the Western Pacific Region

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ABSTRACT

In the WHO Western Pacific Region, primary health care (PHC) is considered 'the future of health' and the key to achieving universal health coverage. However, political, economic and social forces underlying curative, hospital-centric models have eroded public, local-level health service capacity—contributing to fragmented systems and persisting health inequities. Drawing insights from seven published country case studies from East Asia examining PHC in the context of the COVID-19 pandemic, this paper discusses key factors influencing the implementation of PHC. Countries are improving service delivery through a PHC approach, but persisting governance and structural barriers to PHC reform include vertical approaches to health care planning and programme delivery, health workforce shortages and maldistribution, and market forces that have shaped health care and workforce models towards curative care. Three domains for future policy and research to strengthen PHC are proposed. First, managing the political economy of PHC reform requires mapping relationships and systematically unravelling political, social and economic factors shaping accountability, receptiveness and capacity for change. Second, strengthening participatory governance involves shifting power to communities through platforms for shared policy creation and implementation, decentralised governance and empowering community-oriented health workers. Third, improving conceptual clarity and policy guidance on PHC can use the Sustainable Development Goals to orient systems towards preventing illness and valuing good health. The case studies offer a practice model of applied health policy and systems research coproduced with policy stakeholders.

SUMMARY BOX

- ⇒ In the WHO Western Pacific Region, primary health care (PHC) is considered 'the future of health' and the key to achieving universal health coverage.
- ⇒ The transition from Millennium Development Goal to Sustainable Development Goal (SDG) -thinking and action is challenging. Despite the shift to SDGs, investments in PHC reforms remain vertical, disease-focused and hospital-centric.
- ⇒ Key PHC enablers include value-based payment models, decentralised government decision-making, community-oriented health workforce models, platforms for community engagement and PHC policy that addresses the social determinants of health concomitantly with improving clinical care services.
- ⇒ Realising the unfinished agenda to implement PHC is likely to require further work in three key areas: managing the political economy of health system reform; strengthening participatory governance; and improving PHC conceptual clarity and policy guidance.
- ⇒ Policy spaces such as regional and country dialogues that convene decision-makers can play a role in sharing knowledge as well as creating and adapting tools and guidance to strengthen PHC.

INTRODUCTION

In the WHO Western Pacific Region—home to 1.9 billion people or almost a quarter of the world's people living in 37 geographically, ethnically and economically diverse countries—primary health care (PHC) is considered 'the future of health' and the key to achieving universal health coverage (UHC).[1] Yet, 7 years from the 2018 Astana Vision for PHC[2] and 47 years after the 1978 Alma-Ata Declaration,[3] selective PHC approaches still dominate, emphasising vertical, disease-based treatment and prevention rather than horizontal investments in health systems to address population health inequities.[4 5] Across the Region, health inequities persist both within and between countries.[1] Growing rates of non-communicable diseases (NCDs) are being driven by a high prevalence of risk factors including tobacco and alcohol use, physical inactivity, poor diets and air pollution.[1 6] These challenges, added to persistent communicable disease incidence, environmental threats and an ageing population (the proportion of people aged over 60 years

is expected to double across the Region by 2050), are increasing demand for and costs of health services.[1]

Gaps in PHC—including low levels of spending on primary care, fragmented services and hospital-centric models—are likely to undermine the ability of the Region's health systems to meet present and future health needs.[1] Failing to counter trends that prioritise disease-based and curative care models will reduce both health equity and health system sustainability.[7] Responding to the health impacts of climate change also presents a key challenge, particularly for poorer nations and low-lying areas.[8]

Globally, investments in PHC have improved life expectancy, health equity and healthcare access.[9] The impacts of the COVID-19 pandemic from 2020 shone a new spotlight on PHC, highlighting its role in enabling effective pandemic responses. To capture key lessons in the pandemic context, the Alliance for Health Policy and Systems Research (a WHO-hosted partnership) together with WHO Regional Offices commissioned case studies examining PHC in the context of the complex unfolding public health emergency in nearly 50 countries.[10] Led by in-country authors, seven case studies were conducted with the WHO Western Pacific Regional Office between 2021 and 2023 in: Lao People's Democratic Republic (Lao PDR), Malaysia, Mongolia, Philippines, Republic of Korea, Singapore and Viet Nam (figure 1).[11–17] These studies, reflecting experiences in a subset of countries in the WHO Western Pacific Region all located in East Asia, draw from document review and consultations with PHC experts and policymakers to examine PHC in the COVID-19 context.

This paper discusses key factors influencing the implementation of PHC approaches in the Region, drawing on findings from the seven East Asia-based PHC case studies (specific experiences in other countries in the Region including small Pacific Island states are not directly addressed). As in the case studies, the analysis is structured using the WHO Western Pacific Region's Member State-endorsed set of five strategic actions for PHC: (1) build appropriate models of service delivery; (2) empower individuals and communities to participate

Figure 1 Map of countries in which PHC case studies were conducted in the WHO Western Pacific Region (using *mapchart.net*). PHC, primary health care.

Table 1 Insights from the seven case studies on how countries in the region are improving service delivery through a PHC approach

Country	Actions to improve service delivery through a PHC approach
Lao PDR	The country's Policy on PHC (2000, revised 2019) defines PHC concepts, approaches and principles and guides healthcare policy, supported by a health financing strategy that enables a transition from donor to domestic funding for health. PHC is identified as a core pathway to achieve universal health coverage as part of a broader decentralisation process that aims to strengthen district-level management and planning.
Malaysia	The government introduced the Enhanced Primary Health Care initiative in 2017 to establish person-centred healthcare bundles and integrated care networks, along with new care coordinator roles. The *Agenda Nasional Malaysia Sihat* was also introduced in 2021 to facilitate 'health in all policies' through collaboration between government agencies. The 2023 Malaysia Health White Paper emphasises wellness, health promotion, preventive care and community-level healthcare delivery, with PHC at the centre.
Mongolia	The government has piloted a budget planning process linked to the Sustainable Development Goals (SDGs) in the health sector. This has involved primary care services and enabled the integration of health and social protection objectives to improve the social determinants of health.
Philippines	The establishment of local health provider networks (HCPNs) aims to improve coordination between public and private healthcare facilities. The National Unified Health Research Agenda 2017–2022 has six themes that are important for PHC: responsive health systems, enhancing and extending healthy lives, holistic approaches to health and wellness, health resiliency, global competitiveness and innovation in health and health equity.
Republic of Korea	The government has led initiatives to strengthen PHC through chronic disease management and integrated community health promotion programmes. The Department for Improving Primary Care was established in 2022 to improve financial sustainability of the health system and to shift its orientation from primary *medical* care to a more comprehensive approach.
Singapore	The country is implementing a 'life-course' approach to PHC aligned with the 2022 White Paper on a Healthier Singapore: mobilise family doctors to deliver preventive care; develop health plans with lifestyle adjustments and regular health screening; mobilise community partners to support healthier lifestyles; launch a family doctor enrolment exercise; and strengthen information technology, workforce and financing. The Ministry of Health is working closely with regional healthcare clusters, family doctors and community partners to implement the plan.
Viet Nam	The government has implemented reforms to shift healthcare from hospital-based provision to primary care, disease prevention and health promotion, leveraging the country's grassroots healthcare network. Reforms have included increased investment in grassroots facilities, support for greater district health worker mobility, addition of preventive care to the scope of services funded publicly and introduction of a family medicine model. The Ministry of Health has also been delegated clear responsibilities to implement social development targets aligned to the SDGs under the National Action Plan for the Implementation of the 2030 Agenda for Sustainable Development.

PDR, People's Democratic Republic; PHC, primary healthcare.

in health; (3) build a fit-for-purpose health workforce; (4) realign PHC financing; and (5) create a supportive and enabling environment.[1] To generate cross-case insights, we used these action categories to produce a matrix summarising the case studies' main findings and explored existing evidence on each topic.

APPROPRIATE MODELS OF SERVICE DELIVERY

Countries in the Region have enacted major PHC reforms in recent years, reaffirming the modern relevance of the Alma-Ata principles (table 1). A 2022 White Paper on a Healthier Singapore, for instance, reflects a culmination of systematic efforts to reform the health system under the country's Health Care 2020 Master Plan.[15] Given an ageing population and growing incidence of complex chronic conditions, the White Paper commits the government to strengthen community participation, public–private collaboration, multisectoral approaches to public health planning and preventive public health services.[15] Another example is Viet Nam's grassroots healthcare network, which has shifted healthcare from hospital-based provision to primary care, disease prevention and health promotion.[18]

However, countries are struggling to navigate complex systems change while working with legacy structures of siloed government departments and fragmented information systems.[1] The United Nations Millennium Development Goals (MDGs—2000–2015), focused on improving maternal health, reducing child mortality and combating HIV/AIDS and malaria, reinforced these siloed functions within health systems, contributing to selective, disease-oriented approaches to PHC.[19] Many countries in the Region have seen significant improvements across a range of MDG targets including infant, child and maternal mortality—such as Cambodia and Viet Nam,[18 20] where PHC efforts have been instrumental to this success. However, as in other regions, siloed, disease-specific programmes and infrastructure have been poor foundations for systems that anticipate and respond to demographic and epidemiological transitions, including the new investments and approaches needed to address NCD risk factors.[1 21]

Health ministries have faced challenges in shifting from the MDGs to the Sustainable Development Goals (SDGs—2015–2030), which emphasise broader complex systems approaches.[22 23] As one of the SDG3 Global Action

Plan's seven 'accelerators', PHC is key to achieving the health-related SDGs following the MDGs,[24] but there is lagging adoption and implementation of key concepts such as people-centred care, reshaping accountabilities and promoting and protecting the health of communities.[25 26] Along with weak political commitment[22] and limited technical guidance to support integrated healthcare planning,[23] resource constraints within health ministries and disease-based vertical or parallel funding from donors may have contributed to the ongoing dominance of selective PHC approaches[4]—as seen in Lao PDR, where horizontal coordination across technical centres established in the MDG era remains a challenge.[16] Nonetheless, the SDGs are being used by countries in the Region (including Mongolia[12] and Viet Nam[18]) to frame the PHC concept and, in turn, health service investment and reform decisions.

EMPOWERING INDIVIDUALS AND COMMUNITIES TO PARTICIPATE IN HEALTH

Varied models and approaches are used to enable community engagement and participation in healthcare planning. In Viet Nam, Steering Committees for the Care and Protection of People's Health, involving representatives from the government, civil society organisations and community groups such as schools, operate at the community level to guide the implementation of health protection and promotion activities.[18] Another example is the Republic of Korea's Health and Welfare Social Cooperatives, which are voluntary organisations that facilitate community participation.[14] The cooperatives offer a model of how to institutionalise public participation in healthcare decision-making and strengthen primary care and preventive public health functions.[14]

In many of the Region's countries, however, gaps remain in community participation in healthcare decision-making and priority setting.[1] Low healthcare quality, high out-of-pocket health costs and high variation in healthcare access based on geography and wealth are indicative of gaps in community outreach and limited community engagement, leadership and engagement.[1] COVID-19 reaffirmed the importance of community trust and participation for pandemic responses and for effective health system functioning, prompting new engagement efforts as seen in Lao PDR, Singapore and Viet Nam.[15–17] For example, as part of the pandemic response, the Lao PDR Ministry of Health field tested a new training module in health centres at the village level on people-centred care to improve mental well-being, which was integrated into preservice training with other modules on local governance and community engagement.[16] Countries were also able to leverage existing governance and structural enablers of public engagement, reaffirming their importance. In Mongolia, for example, local governments at subdistrict levels involved citizens in decision-making to define responsibilities to support affected households—showcasing how decentralised governance systems can empower individual and community participation.[12] Other studies have similarly demonstrated how crises can create windows of opportunity to encourage public participation, transparency and accountability in health systems.[21] Reflecting learnings from the COVID-19 pandemic and a need for multifaceted approaches, the PHC case studies identify opportunities to strengthen community empowerment and participation (table 2).

A FIT-FOR-PURPOSE HEALTH WORKFORCE

Meeting the Region's health needs requires a health workforce that enables continuous, coordinated and people-centred care consistent with a PHC approach.[27] Workforce cadres enabling a fit-for-purpose PHC workforce in the Region include nurse practitioners trained and supported to deliver health counselling, chronic disease management and public health functions[15]; care coordinators for chronic disease[15]; physicians specialising in family medicine[14 15] and multidisciplinary teams comprising dental officers, nutritionists, pharmacists,

Table 2 Opportunities identified in the seven case studies to strengthen community empowerment and participation

Country	Opportunities to strengthen community empowerment and participation in the future
Lao PDR	Improving community trust in the health system and sustaining community structures and capacities such as decentralised and multisectoral emergency responses that shifted power and ownership to the community.
Malaysia	Scaling up successful initiatives that use innovative digital platforms and in-person interactions to improve the accessibility of health-related messages.
Mongolia	Empowering leadership by local governments to enable community engagement.
Philippines	Strengthening People's Councils, involving government and civil society groups, as key platforms for shared policy creation and implementation. Coaching and mentoring of health system leaders to prioritise PHC reform and eliminate barriers to individual empowerment.
Republic of Korea	Overcoming medical professionalism, paternalism, information asymmetry, competition and market orientation of the health system.
Singapore	Facilitating collaboration between communities and the health ministry to shape PHC reform implementation.
Viet Nam	Improving community knowledge about health and peoples' confidence and skills to participate in health-seeking activities.

PDR, People's Democratic Republic; PHC, primary healthcare.

medical laboratory technologists, occupational therapists and physiotherapists.[11] Community health workers play a pivotal role in delivering culturally responsive health education and basic healthcare at the local level, as seen in Lao PDR and Viet Nam.[16 17] Lao PDR's new community-oriented workforce cadre—Village Health Workers (VHWs)—strengthens primary care services and community participation in health service implementation in rural areas.[16] The VHW programme, introduced as part of the country's Health Sector Reform Strategy by 2025,[28] are village health volunteers that receive additional training to support outreach, health promotion, and coordination between villages and districts.[16]

By increasing demand on the health system, the COVID-19 pandemic incentivised innovative workforce models such as deployment of private or voluntary healthcare personnel in public facilities,[15] task-shifting within the public health workforce,[11] redeployment of personnel to areas of need,[13] training in people-centred care[16] and new measures to protect healthcare workers from infection.[12] As in other regions, the pandemic also exposed health workforce shortages, inadequate skill mixes and maldistribution.[27] Among WHO Western Pacific countries at all income levels, market forces have shaped health workforce models towards curative care as well as payment and purchasing mechanisms that fail to keep populations healthy and a limited role for community input into decision-making.[1] PHC-oriented health workforce reforms, such as shifting from specialist to generalist training models, are therefore likely to require examining accountability and shifting power structures.[27] In Lao PDR, for example, challenges such as population ageing and multimorbidity require PHC-oriented workforce competencies, information systems and modalities of working; yet these contrast with vertical approaches that have contributed to fragmented systems and increased the technical and management burden at lower levels of the health system.[16]

PHC FINANCING

Equitable approaches to health system financing underpin strong primary care and efforts to expand and sustain UHC.[22] While some countries (including Lao PDR and Viet Nam) are investing in efforts to implement UHC by reducing out-of-pocket costs,[16 17] significant challenges remain.[14] Institutional interests driving a market orientation of the health system is a key barrier to PHC-oriented financing reform.[1] For example, interest group opposition and public opinion resistant to changing the status quo have inhibited healthcare financing reform in Malaysia, despite a pressing need to re-orient healthcare budget allocations away from hospital-centric acute care models.[11 29] Against this backdrop, Malaysia's 2023 Health White Paper demonstrates a wide political consensus to emphasise wellness, health promotion, preventive care and community-level healthcare delivery[11] and includes oversight by an independent body as well as strategies to implement innovative and value-based payment models. Ongoing political commitment and support from key stakeholders including the community will be vital to ensure the success of this reform.[30]

In the Republic of Korea, too, the dominance of specialists and private hospitals is linked to powerful pharmaceutical and technology industry influence that has eroded public sector capacity and pandemic preparedness.[14] During the pandemic, public hospitals that account for only about 5% of all hospitals took responsibility for almost 80% of patients with COVID-19, as the main responsibility for the COVID-19 response fell to public health centres.[14] Recognising the essential role of PHC for financial sustainability, the government's Health Insurance Review and Assessment Service (a government agency under the Ministry of Health and Welfare) established the Department for Improving Primary Care in 2022.[14]

These experiences underscore the political nature of PHC financing: pivoting hospital-centric and specialist service models towards PHC requires managing political, social and economic factors including the political motivations, structure of the economy and social conditions shaping receptiveness and capacity for reform and change.[31] Understanding these factors is essential to help with future PHC reform in the Region.[21]

A SUPPORTIVE AND ENABLING ENVIRONMENT

A supportive and enabling environment encompasses policy and regulatory frameworks, digital infrastructure, governance and management of integrated services across sectors and mechanisms that promote learning and improvement.[1] Platforms and approaches that enable multisectoral collaboration are essential to address the socioeconomic and environmental determinants of increasing NCDs across the Region, which include population ageing, poverty, education, stress, culture and social norms, urbanisation, industrialisation, state policy, pollution and food and activity environments.[1 6] In countries across the Region, COVID-19 catalysed the establishment of new multisectoral partnerships and programmes at local and national levels. In Lao PDR, for example, COVID-19 prompted decentralised multisector responses with oversight by provincial and district governments.[16]

However, despite being a core component of the Astana PHC vision and Regional PHC Framework, multisectoral policy and action remain missing from PHC reform efforts.[1 4] Moreover, while new multisector platforms can be impactful, governance and structural changes can also be superficial (continuing to perpetuate the status quo), disconnected from the existing evidence base, process-oriented or driven by cost-cutting imperatives. In the WHO Western Pacific Region, as in other regions, these superficial efforts can be and are often still characterised as PHC reform, reflecting a persistent policy-practice gap.[32]

Countries can be better supported by global health institutions to access, interpret, adapt and implement the vast and growing body of knowledge on systems approaches to build a supportive and enabling environment for PHC.[33] Systems thinking considers connections between multiple interacting agents in dynamic and non-linear contexts within a 'whole', or a common purpose.[34] Theories, methods and approaches to address key challenges, such as fragmented decision-making, include path dependency theories and systems dynamics modelling, supported by tools such as causal loop diagrams and process mapping.[34]

CONCLUSION

COVID-19 shone a spotlight on the need for systems approaches to achieve *health for all* as the pandemic stalled decades of economic growth and progress towards SDG targets.[35] The pandemic also drew renewed attention to the unfinished agenda to realise the PHC approach first codified nearly half a century ago—to move beyond vertical, programmatic approaches historically dominating communicable disease control.[36] Lessons from the implementation of PHC policy underscore that there is no universal blueprint; implementation is a complex process involving trial and error and learning from mistakes.[19] Collecting and reporting country-level evidence to develop contextualised insights, as conducted in the seven PHC case studies from the WHO Western Pacific Region, can motivate and shape policy reforms.[37] This analysis, using the five PHC strategic actions in the PHC Regional Framework[1] to discuss insights from the seven case studies, suggests three domains for future policy and research: managing the political economy of health system reform; strengthening participatory governance; and improving conceptual clarity and policy guidance around the PHC concept.

First, political economy factors are reflected in the political, economic and social forces that continue to underlie curative, hospital-centric models in countries across the Region. Despite reforms that have improved the coordination of care between acute and primary care services and integration of services for specific conditions, curative medical care models still dominate.[7] The Region's health systems are not yet achieving the Astana PHC vision of meeting all people's health needs across the life course through comprehensive services and care,[38] indicating a need for greater efforts to strengthen public, local-level health service capacity and to draw both policymaker and broader societal attention persisting health inequities. Since the Lancet Global Health Commission on financing PHC, there is renewed awareness that relying exclusively on technical solutions to these challenges is likely to fail, pointing to the importance of political economy factors.[31] Yet, more empirical studies that examine political economy factors in the Region are needed.[21] The WHO's 2024 'how to' guide for political economy analysis for health financing offers a structure to organise political economy factors to address key elements systematically.[39 40] The guide is intended to be used flexibly and adapted to context and involves the following six steps[21]: (1) assemble/identify the strategic or 'change team'; (2) select reform or group of reforms to analyse; (3) understand the reform context; (4) stakeholder mapping; (5) strategising (ie, asking what can be done to make the reform happen or find a solution that meets the objective?) and (6) follow-through of reforms and monitoring of stakeholder management strategies' effectiveness. Such studies and analyses can enable a strategic approach to reform building on an understanding of factors that determine how resources are allocated and used.[39 41]

Second, countries in the Region can invest in strengthening participatory governance, leveraging extant policies and platforms that empower individuals and communities to manage their health and participate in healthcare planning. Collaboration between service providers, policymakers and communities is fundamental to PHC and involves identifying the interests and priorities of community stakeholders at three interlinked levels: health system governance, planning and priority setting, and implementation of health services.[42] Formalised processes of participatory governance are likely to require shared decision-making spaces with local mid-level managers[1] as well as empowered individuals who have the knowledge and skills to coproduce health decisions.[43] As community participation in PHC decision-making is an inherently political process involving the transfer of power and influence,[36] such efforts should consider socioeconomic contexts, power dynamics influencing representation of community voices and cultural and organisational issues that shape engagement with communities.[44]

Third, greater conceptual clarity and policy guidance on PHC may help to bridge the policy-practice gap observed across the Region's five strategic actions for PHC. Both the Alma-Ata and Astana PHC Declarations, reflecting broad political vision and intent, lack operational detail on the specific actions needed to make *health for all* a reality.[38] Notwithstanding the specific guidelines and frameworks that have been developed to operationalise these broader statements, implementing PHC aspirations remains challenging for governments, and particularly health ministries in the Region.[9] Advocacy through conceptual documents, strategies and evidence syntheses can prompt policymakers to establish policy spaces for identifying innovations and shaping action. Regional dialogues that bring together decision-makers can help with this advocacy through facilitating knowledge sharing, peer-to-peer learning and coproduction and adaptation of tools and guidance. Monitoring and evaluation of the reform process, outputs and outcomes are also essential to track how countries are transforming PHC.[42]

The seven case studies in the WHO Western Pacific Region describe current approaches and future

opportunities to meet the region's challenges through strengthening PHC, producing insights that can help countries realise the unfinished agenda to implement PHC. While the case studies also offer a practice model of applied health policy and systems research coproduced with policy stakeholders, methodological limitations should be noted. The case studies used desk-based review and consultations with health system actors but lacked perspectives from community members and stakeholders in other (non-health) sectors, which limited in-depth exploration of key challenges and opportunities shaping PHC reform. We accounted for this limitation in this analysis by drawing on a broader literature to understand the insights from the case studies. Given the breadth of PHC aspects explored in the case studies and their relative brevity, future case study research and comparative analyses at both country and region levels might also seek to examine specific factors influencing PHC reform in more depth, such as the influence of market forces on health workforce composition.

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REFERENCES

1 World Health Organization Regional Office for the Western Pacific. *Regional framework on the future of primary health care in the western pacific*. Manila: World Health Organization, 2023.
2 World Health Organization and United Nations Children's Fund. *Global conference on primary health care: Astana, Kazakhstan, 25 and 26 october 2018*. Geneva: World Health Organization, 2018.
3 Declaration of Alma-Ata. *WHO Chron* 1978;32:428–30.
4 Rasanathan K, Evans TG. Primary health care, the Declaration of Astana and COVID-19. *Bull World Health Organ* 2020;98:801–8.
5 Walsh JA, Warren KS. Selective primary health care: an interim strategy for disease control in developing countries. *Soc Sci Med Med Econ* 1980;14:145–63.
6 Peng W, Zhang L, Wen F, *et al*. Trends and disparities in non-communicable diseases in the Western Pacific region. *Lancet Reg Health West Pac* 2024;43:100938.
7 Freijser L, Annear P, Tenneti N, *et al*. The role of hospitals in strengthening primary health care in the Western Pacific. *Lancet Reg Health West Pac* 2023;33:100698.
8 Kadandale S, Marten R, Dalglish SL, *et al*. Primary health care and the climate crisis. *Bull World Health Organ* 2020;98:818–20.
9 Edelman A, Marten R, Montenegro H, *et al*. Modified scoping review of the enablers and barriers to implementing primary health care in the COVID-19 context. *Health Policy Plan* 2021;36:1163–86.
10 Alliance for Health Policy and Systems Research. Primary health care case studies in the context of the covid-19 pandemic. Geneva: World Health Organization; 2023. Available: https://ahpsr.who.int/what-we-do/thematic-areas-of-focus/primary-health-care/primary-health-care-case-studies-in-the-context-of-the-covid-19-pandemic
11 Wen Huey Lee S, Amer Nordin A, Saw PS, *et al*. Malaysia: a primary health care case study in the context of the covid-19 pandemic. Geneva: World Health Organization; 2023. Available: https://ahpsr.who.int/publications/i/item/malaysia-a-primary-health-care-case-study-in-the-context-of-the-covid-19-pandemic
12 Ankhbayar B. Mongolia: a primary health care case study in the context of the covid-19 pandemic. Geneva: World Health Organization; 2023. Available: https://ahpsr.who.int/publications/i/item/mongolia-a-primary-health-care-case-study-in-the-context-of-the-covid-19-pandemic
13 Gomez-Chua K, Dunlao K, Abesamis LEA, *et al*. Philippines: a primary health care case study in the context of the covid-19 pandemic. Geneva: World Health Organization; 2023. Available: https://ahpsr.who.int/publications/i/item/philippines-a-primary-health-care-case-study-in-the-context-of-the-covid-19-pandemic
14 Kim S-Y. Republic of Korea: a primary health care case study in the context of the covid-19 pandemic. Geneva: World Health Organization; 2023. Available: https://ahpsr.who.int/publications/i/item/republic-of-korea-a-primary-health-care-case-study-in-the-context-of-the-covid-19-pandemic
15 Phua KH. Singapore: a primary health care case study in the context of the covid-19 pandemic. Geneva: World Health Organization; 2023. Available: https://ahpsr.who.int/publications/i/item/singapore-a-primary-health-care-case-study-in-the-context-of-the-covid-19-pandemic
16 Kounnavong S, Siengsounthone L, Vonglokham M. Lao people's democratic republic: a primary health care case study in the context of the covid-19 pandemic. Geneva: World Health Organization; 2023. Available: https://iris.who.int/bitstream/handle/10665/372688/9789240076709-eng.pdf?sequence=1
17 Tran Thi Mai O, Nguyen TT, Cuc Nguyen TT, *et al*. Viet nam: a primary health care case study in the context of the covid-19 pandemic. Geneva: World Health Organization; 2023. Available: https://ahpsr.who.int/publications/i/item/viet-nam-a-primary-health-care-case-study-in-the-context-of-the-covid-19-pandemic
18 Oanh T, Thang N, Thu C, *et al*. *Viet Nam: a primary health care case study in the context of the COVID-19 pandemic*. Geneva: World Health Organization, 2023.
19 Rifkin SB. Alma Ata after 40 years: Primary Health Care and Health for All-from consensus to complexity. *BMJ Glob Health* 2018;3:e001188.
20 Cuenca-García E, Sánchez A, Navarro-Pabsdorf M. Assessing the performance of the least developed countries in terms of the Millennium Development Goals. *Eval Program Plann* 2019;72:54–66.

21 Witter S, Bertone MP, Baral S, *et al*. Political economy analysis of health financing reforms in times of crisis: findings from three case studies in south-east Asia. *Int J Equity Health* 2025;24:34.
22 Hone T, Macinko J, Millett C. Revisiting Alma-Ata: what is the role of primary health care in achieving the Sustainable Development Goals? *The Lancet* 2018;392:1461–72.
23 Hatefi A, Sekhri N, Debas H, *et al*. Health Affairs Blog. *Washington DC: Health Affairs* 2016.
24 Chotchoungchatchai S, Marshall AI, Witthayapipopsakul W, *et al*. Primary health care and sustainable development goals. *Bull World Health Organ* 2020;98:792–800.
25 World Health Organization. *World health report 2008 - primary health care: now more than ever*. Geneva: World Health Organization, 2008.
26 Gauld R, Blank R, Burgers J, *et al*. The World Health Report 2008 - Primary Healthcare: How Wide Is the Gap between Its Agenda and Implementation in 12 High-Income Health Systems? *Healthc Policy* 2012;7:38–58.
27 World Health Organization. Regional framework to shape a health workforce for the future of the Western Pacific: World Health Organization. *Regional Office for the Western Pacific* 2024;Available from. Available: https://iris.who.int/bitstream/handle/10665/376704/9789290620488-eng.pdf?sequence=1
28 Nonaka D, Inthavong N, Takahashi K, *et al*. Primary health care situations in remote rural villages of the Savannakhet province, Lao People's Democratic Republic. *Trop Med Health* 2022;50:90.
29 Croke K, Mohd Yusoff MB, Abdullah Z, *et al*. The political economy of health financing reform in Malaysia. *Health Policy Plan* 2019;34:732–9.
30 Che Soh M, A. Samad S, Yusof R, *et al*. Assessing Malaysian Health Care Reform. *E-BPJ* 2024;9:185–91.
31 Hanson K, Brikci N, Erlangga D, *et al*. The Lancet Global Health Commission on financing primary health care: putting people at the centre. *Lancet Glob Health* 2022;10:e715–72.
32 Gore R, Topp SM, Banach M, *et al*. What can we learn from developments in primary health care in south Asia? *Lancet Glob Health* 2024;12:e1575–6.
33 Marten R, Kadandale S, Nordström A, *et al*. Shifting global health governance towards the sustainable development goals. *Bull World Health Organ* 2018;96:798.
34 Peters DH. The application of systems thinking in health: why use systems thinking? *Health Res Policy Syst* 2014;12:51.
35 World Health Organization Regional Office for South-East Asia. *South-east Asia regional strategy for primary health care: 2022-2030*. New Delhi, India: World Health Organization, 2021.
36 Segall M. The Politics of Primary Health Care. *The IDS Bulletin* 1983;14:27–37.
37 Sheikh K, Ghaffar A. PRIMASYS: a health policy and systems research approach for the assessment of country primary health care systems. *Health Res Policy Syst* 2021;19:31.
38 Walraven G. The 2018 Astana Declaration on Primary Health Care, is it useful? *J Glob Health* 2019;9:010313.
39 World Health Organization. *Political economy analysis for health financing: a 'how to' guide*. Geneva: World Health Organization, 2024.
40 Sparkes SP, Campos Rivera PA, Jang H, *et al*. Normalizing the political economy of improving health. *Bull World Health Organ* 2022;100:276–80.
41 World Health Organization. Political economy analysis of primary health care–oriented reforms country case study series: world health organization. 2024. Available: https://www.who.int/teams/primary-health-care/evidence-and-innovation/primary-health-care-implementation-solutions-initiative
42 World Health Organization and and the United Nations Children's Fund (UNICEF). *Operational framework for primary health care: transforming vision into action*. Geneva: World Health Organization and UNICEF, 2020.
43 Marten R, Hinton R, Chatfield C, *et al*. Co-production of knowledge must move further and faster to strengthen health systems. *The BMJ Opinion* 2021.
44 Erku D, Khatri R, Endalamaw A, *et al*. Community engagement initiatives in primary health care to achieve universal health coverage: A realist synthesis of scoping review. *PLoS One* 2023;18:e0285222.