Chapter 1
Renewal of Primary Care

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Primary Health Care: Roles and Challenges

Primary health care (PHC) is the focus of the healthcare system (WHO 1985). PHC is regarded as the first and critical portal into the health system (Charif et al. 2017; Blackburn et al. 2018; McMurray and Clendon 2015; Starfield et al. 2005; Welzel et al. 2017). PHC involves a persistent and lifelong dedication to health (Doohan and DeVoe 2017), and it provides people-oriented and people-integrated care gradually (Martin-Misener et al. 2012). PHC is important in improving the management of people's health (Hutchison et al. 2011). Patients treasure better access to primary care services as one of the priorities (NHS England 2017), and such improvement is also one of the goals of healthcare system (Corscadden et al. 2018).

The definition of PHC varies with countries (Kronenberg et al. 2017). McMurray and Clendon (2015) defined PHC as a set of principles which escort healthcare professionals in helping people to achieve good health via fair and equitable means. Junod Perron et al. (2018) view PHC as the provision of integrated accessible healthcare services and the development of a sustained partnership between physicians and patients. PHC is intersectoral, and its planning should be in liaison with various sectors concerned with health aspects of the community (McMurray and Clendon 2015).

Primary health care serves multiple roles for the population. PHC is viewed as evolving to reduce health disparities while improving outcomes and quality (Kapadia 2018). Strong PHC is crucial to an efficient and effective health system and equitable healthcare delivery systems (Dullie et al. 2018; Leach et al. 2017).

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Strengthening of PHC is conducive to a more equitable and accessible care system which produces better health outcomes at lower cost (Wong et al. 2017). Countries with sufficient access to primary care enjoy health and economic benefits (Charif et al. 2017; Phillips and Starfield 2003; Ranstad et al. 2017).

PHC is also facing multiple challenges. First, the demand for PHC is expected to increase (Wen et al. 2018; Nathan et al. 2017) in view of the challenge of ageing population with more chronic diseases (Vestjens et al. 2018). Ageing population would induce higher utilisation of PHC services among the elderly and cast considerable consequences on healthcare resources (Welzel et al. 2017). Second, expansion on research on the primary care activities is needed (Adar et al. 2017). To promote widespread adoption, researches which address the feasibility, effectiveness and efficiency in the primary care context are needed (Klein et al. 2017). A renewal of PHC is timely in responding to the ever-changing world and puts people at the core of health again.

Health for All: Declaration of Alma-Ata

In 1978, the historical Declaration of Alma-Ata (the Declaration) at the International Conference on Primary Health Care of the World Health Organization (WHO) marked a shining moment in the human history of public health. The Declaration provides guidelines, principles and values for the world to develop and promote primary care, which is the key to "Health for All (HFA) by the Year 2000" (WHO 1978). Investing more in primary healthcare interventions may accelerate the achievement of Sustainable Development Goals (SDGs) of universal health coverage (Dullie et al. 2018). The need of a robust primary care system was echoed strongly three decades later in the WHO's World Health Report 2008, *Primary Health Care: Now More Than Ever* (Brown et al. 2016).

Primary health care was defined by the WHO's *Declaration of Alma-Ata* (1978) as follows:

> *Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination… It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*

Primary health care is based on the concepts of equity, access, empowerment, community self-determination and intersectoral collaboration. It involves various stakeholders and is associated with economic, social, political, environmental and cultural factors of health. Health promotion, disease prevention, health education, control over health and well-being by individuals and person-centred holistic care, as well as curative and rehabilitative services, are provided. PHC empowers

individuals to present various health problems and to participate in making decisions on their own health and care (PHAA 2014).

The Declaration aims to protect and promote the health of all people as a fundamental human right and a universal social goal in view of health inequality in various countries. Comprehensive health for all is needed in the sustainable development of economic and social aspects and enhanced quality of life, in the spirit of self-reliance, social justice, equity and universal coverage. Primary health care is the first encounter of individuals with continuing and multidisciplinary health care which is proximal to workplace and residence, under the coordinated efforts of non-health sectors. All governments are urged to formulate policies and action plans for sustainable primary health care by allocating resources to achieve value for money (WHO 1978).

Development of Primary Care

History of Primary Health Care

Primary health care is considered as the latest expression of a philosophical acceptance that major diseases are linked not only to the best science available but also to social fairness and improved life quality for the poor. Dr. Halfdan Mahler, the charismatic Danish doctor, was elected Director General of WHO in 1973 and served three terms until 1988. He shifted WHO's focus and turned his "participatory and bottom-up" initiatives with the goal of "Health for All by the Year 2000" into the Primary Health Care movement, resulting in the Declaration of Alma-Ata and the subsequent radical changes to health systems (Cueto 2004; Unite For Sight 2018).

The subsequent years after the Declaration were not easy. There were some "counter-revolutionary" initiatives by donor nations in adopting "selective primary health care" and structural adjustment policies, selecting low-cost technical interventions, such as vaccination and privatising health services with business management methods in the 1980s by the World Bank. It was a detour from the holistic primary care philosophy. Political commitment was not forthcoming. In 2008, on the 30th anniversary of the Declaration, Dr. Mahler called a halt to seeing things through the medically tainted glasses by attending to the association between health and social, economic and environmental factors. He was responding to the resistance of the doctors who feared of losing privileges, prestige and power in the primary care movement. However, the situation has not changed much over the years in the medical profession worldwide. Primary care is still not considered the mainstream specialisation option for the upcoming young medical graduates. A step forward came in 1997 when a newly proposed target entitled "Health for All in the 21st Century" was put forward in the Pan American Health Organization document. The holistic primary care in the original 1978 proposal was still under planning 20 years later. Perhaps a way to boost the impact of primary care in health is the

study of history (Cueto 2004; Brown et al. 2016; Unite For Sight 2018). Primary health care is revisited through the four selected cases from the developed and developing world, illustrated in the next section.

Ottawa Charter for Health Promotion in 1986

Health promotion entails health education interventions and the related organisational, political and economic supports for making behavioural and environmental changes to improve health. Health education, prevention and protection are the three core components, and lifestyle and social determinants are the major health risk factors. A landmark document entitled "A New Perspective on the Health of Canadians" was presented in 1974 by Marc Lalonde, the then Canadian Minister of Health. The document considered lifestyle, genetic and environmental causes of diseases, as well as social determinants in health (Lalonde 1974). This work was the forerunner to the Ottawa Charter for Health Promotion (the Charter), in which a new framework for health promotion was designed as the ways of achieving health for all, announced at the first International Conference on Health Promotion in Ottawa in 1986 (Tulchinsky and Varavikova 2010; Saskatchewan Health Authority 2018).

Moving from disease prevention to health promotion, the Charter was a continuation of the primary healthcare era, and primary health care was back in the world agenda again with the spotlight on population health. The Charter assisted public health professionals and policymakers to find different practices in working with other disciplines. The first health promotion setting project was the Healthy Cities movement in 1986, with the slogan "Think globally, act locally", and the first Healthy Cities coordinating centre was set up in Liverpool. The objective of the project was to continually enhance the social and physical environments for health protection and sustainable development. The Healthy Cities network now consists of thousands of cities worldwide. Then the Healthy Schools movement follows, recognising schools as a living environment with resources to ensure healthy development of children supported by the family and the community. Similarly, universities may serve as the focal point for health and sustainability (Awofeso 2004; Kickbusch 2007; Potvin and Jones 2011*;* WHO 2018a).

An innovative Campus Health Ambassadors (CHA) programme, in conjunction with the University Health Service, was started at The Chinese University of Hong Kong in 2003. The programme aimed to inspire and train students who are enthusiastically devoted to promote physical and psychological health within the university and to advocate health messages to the community. Universities can provide a place for students to learn healthy living skills; to take on, synthesise and assess perception of healthy living; to discover components of healthy living; and to make responsible health choices for oneself. Furthermore, the Health Promoting Hospitals project began in 1988 promoted the total quality management of hospitals, with the aims of addressing the health of staff and linking the hospitals to the community (WHO 2018a; Fong 2007; Ng et al. 2018).

The Charter covered five key areas of public health actions, healthy public policies, supportive environments, personal skills, community action as well as reorientation of healthcare services, while three basic strategies of health promotion are advocate, enable and mediate. Health naturally exists in where people live, work and entertain. Thus health promotion has to incorporate the social determinants approach, aligning the “old” public health, and a devotion to individual and community empowerment into the new public health. Sir Doctor Michael Marmot has suggested the lack of human autonomy, empowerment and freedom, which are the core values, as the potent cause of ill health. Professor Lester Breslow has described health as a resource for living and defined the Ottawa Charter as constituting the third public health revolution in building health. According to Breslow (2004), the first revolution began in the early half of the nineteenth century to deal with communicable diseases, and the second one took place in the latter part of the twentieth century in combating non-communicable diseases (NCDs) such as heart conditions, diabetes and cancers (Kickbusch 2007; Potvin and Jones 2011; WHO 2018b).

In recognition of the role of health promotion in pursuing health of the population, there are university programmes, professional associations and journals in health promotion. Canada has even established the Ministry of Health Promotion. Moreover, research is a system approach to better understand the values, principles and processes and to assess the outcomes of better health. It will help formulate health-enhancing policies and build effective service capacity in health promotion. Integration of research and practice and innovative development is essential in avoiding implementation gaps, noted by the Seventh WHO Global Conference on Health Promotion in 2009 (Potvin and Jones 2011).

The New Public Health

Public health refers to activities which focus on the whole population or subpopulation groups within a larger population (Guzys et al. 2017). There was agreement within the public health sector by the early 1990s that health promotion, based on the Ottawa Charter, comprised the “new public health”, as a consequence of advances in knowledge, concerns about human rights and appearance of new threats to health. The new public health (NPH) is a philosophy to broaden the older understanding of public health, with the emphasis on individual health, equal access to healthcare services, social and physical environment, political governance as well as social and economic development. Health should also be included in public policy. In fact, new public health is not a new term. It has appeared in publications 30 years ago to present the link of disease prevention with health promotion and social factors (Awofeso 2004; Tulchinsky and Varavikova 2010).

In the twentieth century, public health was given low priority because many countries placed more resources on the costly hospitals and tertiary care and other health needs, while primary care was underprovided. However, modern scientific

advances kept emerging in early detection, prevention and management of chronic conditions and cancers. A wide range of evidence-based scientific, technological and management methodologies is applied in NPH to build up the scientific basis and practice of public health. Thus, the management and public health practitioners have to work with a common language as well as with cultural orientation, in the pursuit of better population health and to avoid policy conflicts over resource allocation in community care. NPH measures and knowledge can then be promulgated in the broad aspects and be implemented in a cost-efficient and cost-effective manner into public health practice for the benefits of the community (Tulchinsky and Varavikova 2010).

New public health also provides an organisational framework which adopts a population-based approach to reflect health as a fundamental human right, public health policies to recognise available technology and current "best practice" standards, and leadership accountability to remain primarily with the government. The question is to put into practice what is already known and to explore solutions to the unknown with optimism, professionalism, verdict and perseverance in a NPH perspective (Tulchinsky and Varavikova 2010). Furthermore, education and training in public health must take into consideration the "new" roles of public health professionals and workers in the rapidly changing environment. They should be equipped with the tools, values and knowledge needed for health improvements beyond the traditional public sector settings (Petersen and Weist 2014).

The Bangkok Charter for Health Promotion in a Globalized World (2005)

In 2005, the Bangkok Charter for Health Promotion in a Globalized World (the Bangkok Charter) was signed at the Sixth Global Conference on Health Promotion held in Bangkok, Thailand. The Bangkok Charter recognised the global expansion of the innovations underlying the Ottawa Charter and the role of health promotion in developing countries where there are increased inequalities. It identified major challenges, actions and commitments required for formulating policies to address the factors of health in a globalised world by approaching the empowered community. Issues of sustainability in health promotion, focusing on the resources required to meet the challenges of the world, such as consumer-led society, changing world environment and urbanisation, were also highlighted. The Bangkok Charter advocated social justice and equality in national and global development. There are four key commitments: a global development agenda with focus on health promotion, a key responsibility for all governments, a main focus of communities and civil society, and a need for good corporate practices. It refined the approach to behavioural, social and environmental factors of health, and the key is on implementation, with an emphasis on strong political action and leadership, broad participation and alliance and sustainable advocacy based on solidarity (De Leeuw et al. 2006; Catford 2009; Potvin and Jones 2011*;* Ontario Health Promotion E-Bulletin 2018).

The World Health Report 2008: Primary Health Care – Now More Than Ever

The HFA movement had little apparent progress after 30 years, and thus the renewal of PHC was suggested in the World Health Report 2008 – *Primary Health Care* (*Now More Than Ever*) (2008 Report). Recommendations include putting people at the centre of health and responding better and faster to the changing world and growing community expectations. Initiatives in reorientation and reform of the healthcare systems shall help reinforce government structures, professional organisations and civil society organisations with solidarity. All government policies should include health so as to respond to the needs of people. Furthermore, resources should be shifted from the costly curative services to PHC that alleviates disease burden through health promotion and early detection of diseases (WHO 2008a).

The 2008 Report described the lost opportunities since the paradigm shift in thinking about health in the Declaration of Alma-Ata. Most health systems still rely on specialised curative care with short-term results of fragmented services. There appears a laissez-faire approach to governance. Four sets of reforms were suggested: universal coverage reforms, service delivery reforms, public policy reforms and leadership reforms driven by shared values. Well-organised multidisciplinary teams increase patient satisfaction and reduce physician and staff burnout (Leach et al. 2017). There shall be multidisciplinary teams, collaboration with services of other sectors, coordinated inputs of hospitals, specialists and community organisations and improved capacity of health authorities to steer PHC reforms. Information technology helps strengthening the potential for enhancing health and health literacy in a well-educated and modernised world. PHC will then be stronger in direction and unity than the conventional delivery model in achieving health for all, particularly in affluent countries where financial means are available to expedite the change from tertiary care to primary care, to generate a healthier policy environment and to establish universal coverage system. Eventually global solidarity can be realised by international cooperation in the conversion of health systems in the world (WHO 2008a).

Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development (2016)

The Shanghai Declaration was very concise and was the outcome of the Ninth Global Conference on Health Promotion held in Shanghai in November 2016. Health and wellness were recognised as being necessary to attain the United Nations Development Agenda 2030 and its Sustainable Development Goals (SDGs). There are other agenda items, including promoting health through works on all the SDGs and making daring political alternatives for health. Enlightened governance is very important for health. Cities and communities are vital settings for health, while health literacy allows and steers equity (WHO 2018c).

Health is recognised as a universal right, a necessary resource for daily living, a shared social goal and a primary political concern for all countries. The United Nations Sustainable Development Goals establish a responsibility to invest in health, to ascertain universal health coverage and to narrow health inequities among individuals of all ages. Health is also considered a political choice. Leaders from all sectors are urged to improve health and well-being in all the SDGs, as a shared responsibility. The Shanghai Declaration aims to hasten the enactment of the SDGs through added political commitment and financial input in health promotion (WHO 2018c).

Primary Health Care Revisited

The World Perspectives

"Health for All by the Year 2000", a banner of the 1978 Declaration of Alma-Ata, intended to change the views of governments and people about how good health was attained and sustained. Governments were committed to take action to achieve the WHO definition of health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" in a "new" global movement. However, the task has confronted some critical challenges to implementation, including defining PHC and putting PHC into practice, translating equity into action, encountering the limitations of community participation and finding finances to support health system reforms (Rifkin 2018).

Over the years, many government and non-governmental organisation (NGO) PHC programmes are still trying to balance the PHC vision and the reality of health service delivery success by studying health impacts and cost-effectiveness. Year 2018 was designated the year of universal health coverage, with a commitment to social justice and the associated coverage to equity and community participation through the support of community health workers (Rifkin 2018). In creating and sustaining comprehensive primary healthcare practices, a political context is required. There should also be co-partnership models and policy development by the government in conjunction with the communities. Community advocacy and engagement in decision-making should be supported. Deploying, empowering and building up social and human resources in developing as well as developed countries are essential in realising the promise of primary health care (Labonte et al. 2014).

Cases of Developed Countries

The Declaration and the Ottawa Charter for Health Promotion in 1986 only attained a limited and technical approach to certain diseases within nations. There are four movements jeopardising the attainment of HFA. First, managerialism – a goals and

targets approach – has restricted the implementation of health promotion in Australia and some industrialised countries by not addressing the social and environmental imperatives and community action. Second, market-dominant economics has been fuelling health inequities in the world and within countries. Third, individualism, with focus on behaviour and lifestyle, has compromised a collective approach to PHC. Fourth, environmental degradation, an increasing global threat to public health, has been neglected in the implementation of HFA. There are suggestions to return to the original and more radical philosophy, reinforcing the approaches of PHC and health promotion with broader goals in order to achieve HFA (Baum and Sanders 1995).

In New Zealand, primary health care has made considerable changes since year 2000. Primary Health Care Strategy was launched to narrow inequalities in health, to involve communities as well as to enhance the prevention and management of chronic conditions by reducing the burden of diseases and the escalating costs of secondary care. Primary health organisations (PHOs) were subsidised on capitation funding by the government. The PHOs were in charge of the primary health care in a region or for a group or particular ethnic group and were founded across New Zealand, with over 90% of enrolment across the nation. They coordinate and reinforce the care providers with an emphasis on population health. Care providers are encouraged to be innovative and to customise their services to the community in keeping people well (WHO 2008b).

To improve access for Maori and other groups, New Zealand health officials have developed a novel, "evolutionary", and yet effective way to treat the local Maori population. The Maori do not perceive hospitals and clinics as friendly environments and are unwilling to attend these institutions. A health facility was set up on the sacred meeting place and staffed by two culturally sensitive general practitioners. The practitioners became well trusted and respected in the Maori community, which then feel more at ease. The primary care service had become so well received that there was a need to extend the opening hours and relocate the clinic to bigger rooms in a new premise. From this experience, building healthcare facilities in venues where the local people feel comfortable has enhanced their utilisation of health care. However, healthcare needs vary tremendously among the groups. Hence, demands of different communities are met by addressing the inequalities in health among the different groups (WHO 2008b).

In France, there is another story of development of primary care, as illustrated by the works of country doctors, who might be called for emergency care in the middle of a meal in the 1950s. This happened around the clock and the doctors literally "belonged" to the patients. This centuries-old, 24-hour primary healthcare service is still carried on today in rural France, irrespective of the changes in modern time, progress in health care as well as cultural, economic and social impacts on life occurring in faraway communities. Country medical practitioners still provide individualised, one-to-one care with empathy, trust as well as an intimate knowledge of individuals. However, it has become harder to recruit young doctors to work in the rural areas, resulting in closing many practices in the last few decades in France. Apart from the perceived harder working conditions, general practitioners do not

want to take more responsibility because there is danger of being challenged, with consequent legal implications (WHO 2008b).

Very much the same case in Asia, French people move from consulting their family doctor to using emergency services frequently. They seek for the best medical care and always wish to travel to Paris and larger French cities with bigger hospitals. Nonetheless, some country medical practitioners adjust to the changes and their diminishing role. They continue to provide personalised services. Doctor-patient relationship, with a strong bond of trust, is still a fundamental part of the treatment process. Furthermore, an arrangement of night and weekend on-call rotation duties of the local doctors has been proven to work well (WHO 2008b).

Cases of Developing Countries

China's barefoot doctor scheme has been well recognised worldwide as a significant reform of medical education. It had substantial influence on the Declaration of Alma-Ata. In 1951, the Chinese central government pronounced essential health care should be provided in villages. The barefoot doctors, together with health workers and epidemic prevention staff, provided primary health care and basic treatment that combined western and traditional medicines from the 1950s. The barefoot doctor scheme was a very practical and effective measure, particularly in the poor rural areas of the time, where medicine and doctors were in short supply. The doctors returned to the villages to continue farming and to practise medicine after a brief duration of training of 3 months to a year. During the Cultural Revolution, many doctors were deployed from urban hospitals to the villages to learn from the local workers and farmers as part of the Down to the Countryside Movement and to demonstrate professionalism (WHO 2008b).

Barefoot doctors in the village had the advantage of being neighbours to the patients. They knew the family situation, lifestyle and habits of the villagers, and thus they could follow up the cases very closely. In the early 1980s, as a movement of the economic liberalisation, barefoot doctors became qualified as village doctors after formal assessment, and those who failed would practise under the supervision of the village doctors. These rural health workers provide primary health care in health education, prevention, maternal and child health services and collect disease information. The access and quality of care have been improving with social and economic developments. However, the services deteriorated when the agricultural part was privatised at around the same time. Village doctors were deprived of their origin of income and many went to work in farming or industry. As a result, diseases that had been eliminated surfaced again in the countryside because of the lack of inoculations and primary healthcare services (WHO 2008b).

Originated in the most populated, predominantly rural nation on earth, the implication of barefoot doctors in rural health care is now widely recognised by

researchers and policymakers in view of the difficulty to mobilise providers to the rural areas. Training local residents appears to be an option and helps to establish sustainability in rural primary health services as human resources and medicine are the key inputs. Chairman Mao Zedong, at the time, "rightly" advocated that 1-year short-term training was enough to train a doctor to cover the needs of primary care in the villages. In recent years the Chinese government introduced new health insurance schemes as a pledge to a primary health system that subscribes social equality and is affordable for all people. The New Rural Cooperative Medical Scheme that was introduced in 2003 is currently covering over 800 million residents in the rural areas, and at the same time public financing of the health system has escalated considerably (WHO 2008b).

Madagascar is an island country off the southeast coast of Africa with a population of 25 million. As the core of the national primary healthcare policy, a project was initiated in 1978 with high expectations of reaching the Alma-Ata goal of health for all by 2000. The local healthcare supply was inadequate. The healthcare provisions and staff situated in the cities were serving the elites. One thousand and five hundred young health aides were sent on foot, bicycles or primitive transport to primary healthcare centres in the rural districts. In the intervening 30 years, mixed results were noted, with progresses in some areas, while not meeting expectation in others. Generally, health outcomes have been improving in terms of life expectancy, infant mortality and combating infectious diseases like poliomyelitis, leprosy and malaria. Only 60–70% of the residents, mainly in areas linked by roads, have ready access to primary health care at basic health centres which were renamed in the mid-1990s and staffed by nurses. Many people still have to walk some 10 km to receive care, although mobile health centres have been set up in remote villages (WHO 2008b).

Many of the basic health centres were understaffed, ill-equipped with essential drugs and in poor state. The government launched *The Madagascar Action Plan 2007–2012*, comprising eight commitments, as the key policy of Malagasy. Commitment five of the action plan describes the national framework on health, family planning and HIV/AIDS with the aims to provide quality health services to all and promote hygienic practices. The Declaration of Alma-Ata continues to be the cornerstone of primary health care, and the responsibility to attain the HFA goal has been in the hands of individual communities since 2007 (WHO 2008b).

There are some major challenges arising from local cultural beliefs and psychological barriers in the primary care system. Villagers resist education programmes for better personal health and cleanliness, and some even reject the health workers from the lack of trust. Some people have no interest in primary care. They are not aware of the importance of modern practices and regard them as counter to traditional customs. Thus, assuring people of the gains of good health care needs sensitivity and adaptability, and educating rural people in Madagascar can be challenging. Primary health care is all about going back to the basics as far as the local communities and their tradition are concerned (WHO 2008b).

Priority Setting in Primary Health Care

Priority setting is about making choices and is necessary in all healthcare systems where needs and demands commonly exceed the available resources. It is a complicated interaction of different decisions at various levels within an organisation or government. Priority setting process should be transparent and follow ethical principles related to human dignity, community needs and cost-effectiveness (Arvidsson et al. 2012).

In Hong Kong, healthcare reform has been on the public agenda for over 30 years since the “Scott Report” (1985). The Health and Medical Development Advisory Committee in 2005 recommended the four new priorities in the “Building a Healthy Tomorrow – Discussion Paper on the Future Service Delivery Model for our Health Care System”. They include acute and emergency care; services for low-income and underprivileged groups; conditions requiring significant cost, advanced technology and multidisciplinary professional teamwork; and training of healthcare professionals (HMDAC 2005). The report was welcomed by a group of academics in family medicine as “the first Government attempt over the last fifty years to address our health care system as a whole. The system thinking and comprehensive approach demonstrated in this paper are most commendable, … and offers hope for moving our health care delivery system forward” (FMU, HKU 2005).

Since 2005, 14 years have gone by and these priorities have not been “implemented” in the system, which is still “business as usual”. In fact, the four priorities are neither new nor old. They have always been embedded in the public system all these years, as assured by the government that “no one is denied adequate medical treatment due to lack of means”, *a very unique and dogmatic commitment not heard elsewhere in the world*. In priority setting, a number of factors are considered, including the burden of diseases, social determinants, knowledge set, investment and perceived effectiveness of the new choice, or in other words, the needs assessment, financial appraisal, outcome measures, community involvement and ethical consideration (Ng et al. 2019). There is also shared responsibility among the government, care providers, individuals and the entire society to achieve the fair and just choice and decision in the use of social resources.

In primary care, providers should work with the local community to set the priorities to decide health needs and funding of programmes. There are no generally accepted rules in setting priorities, which is a complex, value sensitive, moral and often contested process involving competing interests and political gains. An interdisciplinary and collaborative approach should be adopted with the inputs from health economists, professionals, community leaders, politicians and researchers, especially epidemiologists and policy analysts in building up evidence. A framework has been formulated to describe current knowledge about the services, socio-economic considerations and trade-offs agreed among the stakeholders. It is a useful tool for decision-making in setting priorities for the community systematically. Nonetheless, alignment with the priorities and targets of the government is a crucial deliberation and will help striking the strategic choices and their subsequent success

of implementation. In the longer term, community health plans should be developed to steer priority setting, particularly in response to the changing social, economic, political and professional environment, both locally and internationally (McDonald and Ollerenshaw 2011; Arvidsson et al. 2012).

Evidence-Based Primary Care

Although medicine is often considered an art as well as a science, clinical practice should take into consideration the appropriate evidence in areas where unbiased scientific evidence is available – elements of clinical practice can be quantified. Evidence-based medicine (EBM) is the integration of clinical expertise, patient values and the best evidence into the decision-making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal and unique concerns, expectations and values. The best evidence is usually found in clinically relevant research that has been conducted using sound methodology with mathematical estimates of potential benefit and the risk of possible harm.

EBM aims to apply the best available evidence to unify and standardise treatment and clinical decision-making – *the gold standard*. EBM is not a panacea to the problems of all medical decision-making, but a way to the development of good clinical practice, especially in striking a balance between EBM and individualised patient care when evidence for best practice may not be equally applicable to all patients. Evidence quality can be assessed by meta-analysis, systematic reviews, clinical relevance, risk-benefits analysis, randomised controlled trials, peer reviews, etc. There are limitations of EBM, including cost of studies, time for experiments, generalisability, publication bias – accessibility and representativeness of evidence, ethics and safety issues – and patient concerns.

In primary care, EBM is a useful tool for improvement of the quality of care and in clinical decision-making. Providers are expected to be knowledgeable and comprehensive, while delivering evidence-based primary care effectively. Training in the skills of identifying and applying good evidence is essential. However reliable evidence is not always available, coupled with clinical uncertainty. These drawbacks can be partly solved by the providers' experience, professional expertise and good judgment. Moreover, primary care doctors are concerned that EBM derived from clinical studies is not often applicable to primary care; particularly new knowledge and practice appear all the time. Hence results of research and relevant information should be made easily available and accessible to providers to achieve a highly effective and sustainable primary care system. However, it is difficult to provide evidence-based primary care (EMPC) because of the complexity of information, and there are personal subjectivity and values, as well as emotions and preferences, of providers and patients (Edirne 2012).

Clinical guidelines are usually very imprecise for the complex contexts of primary care, and clinical decisions need to consider family, psychosocial, ethnic,

financial, policy and legislative issues (Edirne 2012). Clinical decisions should routinely be based on evidence that is unbiased and integrated with clinical skills and patient values. Quality of care counts on excellent communication skills and truly informed decision-making in choosing the most relevant rule. Learning from other non-health disciplines, like social sciences and humanities, will improve the application of EBPC. There is a clear need for studies to evaluate improvement in patient-oriented outcomes and high-quality research on common primary care problems in general (Ebell et al. 2017), with the objectives to increase primary care capacity for evidence implementation and to pursue primary care transformation (Shoemaker et al. 2018).

The Way Forward

Forty years have passed since the Declaration of Alma-Ata in 1978. The world is still exploring on how best and practical to pursue the supreme goal of health for all people on the earth. The roles of primary care in the achievement of health and wellness of people in all healthcare delivery systems are well recognised by all stakeholders in the community, including governments, health professionals, academics, politicians, community leaders and the public. Primary care is a complex, adaptive system and is influenced by various interrelated factors (Litchfield et al. 2017). One of the major changes in primary care is the redesign of the entire primary healthcare practice with the support of multidisciplinary teams (Hung et al. 2018). Policymakers should strengthen coordination of care and comprehensiveness in primary care via integration of health systems (Zhong et al. 2018). Based on a US study, Crocker et al. (2017) suggest that an integrative primary care approach can solve the problem of low public satisfaction with the health system. In this connection, an interdisciplinary approach in primary health care is preferred. More integrated interdisciplinary collaboration is needed to meet the future challenges of primary care (Matthys et al. 2017). A primary care-based inter-professional team provides patients with guidance and education to improve their health (Klein et al. 2017).

The authors wish to propose the concept of "interdisciplinary foundation blocks in primary care" that consists of essential components and building blocks to achieve healthy and happy life for all people in the world, irrespective of localities of living, ethnicity, classes, sexes, ages and backgrounds. The interdisciplinary foundation blocks include personal freedom, clean and safe water, adequate food and nutrition, clean air, safe environment, adequate living space, clothing, convenient toilet facilities, happy and harmonious community, banning of harmful substances (such as tobacco, alcohol, drugs, unhealthy food, pollutants, etc.), secured employment and healthy ageing. All responsible governments have the primary duty to ensure the adequate provision, as well as effective and equitable distribution, of the foundation blocks to every individual in the community.

In the real world, such ideal situation may not be attainable due to political, financial, cultural, social and local factors and characteristics. Successful implementation of multidisciplinary primary care is influenced by organisational factors, social factors and policy factors (Leach et al. 2017). In many developed communities, the concern of sustainability of healthcare system and issues of equity, financing health and long-term care are always on the public agenda. These items will affect care delivery and hence health of the future generations. Hence the establishment of an efficient and effective primary care system is fundamental and crucial to any community. Community-based care and practices models of primary care have been introduced to illustrate the important roles of primary care in healthcare systems.

The eight I's approach is adopted in this book to revisit primary care in the ways forward through the various chapters:

1. *Innovation* **–** Renewal of primary care, philosophy of primary health care, the happy university initiative, public health in the context of environment and housing
2. *Integration* **–** Public-private partnership in primary care, healthcare volunteers' significant impacts on primary care, district health systems and capacity building
3. *Infrastructure* **–** Preparedness for disasters in the community, development of care models in community mental health care, health-promoting workplaces, primary care for older adults, palliative care and end of life issues
4. *Integrity* – Equity, quality and gatekeeping, social responsibility and ethics in community health care, health-seeking behaviour doctor shopping
5. *Investment* **–** Sustainable healthcare systems, lifelong education for providers and community
6. *Implementation* **–** Prevention of falls and capturing fractures in the community, community rehabilitation, social marketing in health promotion and behaviours in lifestyle modification
7. *Insurance* **–** Fiscal sustainability challenge and the importance of primary health care
8. *Information* **–** Development and application of mobile technology and Internet of things to aid primary care

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