

2 Conceptual framework for analysing the performance of primary health care

Primary health care (PHC) is well positioned to carry-out three core functions to improve population health and minimise premature mortality. These include providing *health promotion and vaccination, providing screening and early detection of disease, and delivering routine care for underlying health conditions*. There are many key linkages between these core primary health care functions and the ability of countries to respond effectively to the COVID-19 pandemic. Strengthening these core functions will bring benefits during and beyond crises by improving preparedness and resilience of health systems. This chapter presents the conceptual framework used in the report to analyse the performance of PHC in Latin American countries, and it reviews the set of key indicators related to each core PHC function that informs the organisation of the report.

What is primary health care?

Primary health care is expected to be the first and main point of contact for most people with the health care system, focused on the people and their communities. It takes into account the whole person and is patient-focused, as opposed to disease or organ system-focused, and thus recognises not only physical, but also psychological and social dimensions of health and well-being (OECD, 2020^[1]). Key attributes of such a primary health care system include: 1) People and community oriented, 2) Continuous care, 3) Comprehensive care and 4) Co-ordinated care:

- **People and community-oriented:** primary health care operates in close proximity with where people live or work, and provides care that is focused on the needs of local people and their families.
- **Continuous care:** primary health care is the first point of contact with the health system, and the people who use it identify it as their main source of care over time. This implies relational, information and long-term continuity.
- **Comprehensive care:** primary health care addresses the majority of health problems of the people it serves, providing preventive, curative and rehabilitative services.
- **Co-ordinated care:** primary health care helps patients navigate the health system, communicating effectively with the other levels of care. It goes beyond services provided solely by primary health care physicians and encompasses other health professionals such as nurses, pharmacists, auxiliaries and community health workers.

Strong primary health care – that is primary health care system with such key attributes – has been found to improve efficiency, effectiveness and equity across OECD countries (OECD, 2020^[1]). It enables the efficient delivery of crucial health services, including vaccination, screening, early detection of disease and patient-centred management to save lives and money. There is a convincing body of evidence showing that strong primary health care is associated with better health outcomes across OECD countries (OECD, 2020^[1]). A systematic review of 22 studies also shows that care continuity of primary health care practice is associated with lower mortality rates (Pereira Gray et al., 2018^[2]). More recently, a nationwide study of the Norwegian population shows that care continuity in primary health care practice is significantly associated with decreased mortality and reduced acute hospital admissions (Sandvik et al., 2022^[3]). In addition, the cost of providing primary health care is relatively low compared to hospital care, and high performing primary health care reduces the need for more costly interventions, while increasing patient satisfaction. Primary health care is also associated with lower health inequalities as it ensures access to vulnerable population that otherwise can struggle to access medical services due to administrative, financial or geographical barriers (OECD, 2020^[1]).

In low and middle-income countries, strengthening primary health care has also been shown to improve population health outcomes and reduce all-cause mortality, being a cost-effective strategy for achieving universal health coverage. However, available evidence shows that primary health care systems are relatively weaker in low and middle income countries and fail to provide people centred, continuous, comprehensive and co-ordinated care mainly due to under-resourcing, lack of capacity, fragmentation and poor governance (Langlois, 2020^[4]; Bitton, Fifield and Ratcliffe, 2019^[5]).

LAC-7 countries have made great efforts strengthening their primary health care systems to improve the health and health care of their people. Some important progresses can be attributed to the expansion of PHC in the region. Life expectancy at birth continues to rise in LAC-7 countries, reaching 77.9 years on average in 2020 (a gain of almost 3 years since 2000 compared to 3.6 years across other OECD countries). Infant mortality has also been halved over the past two decades, going from 21 deaths per 1 000 live births in 2000 to 10.8 deaths per 1 000 live births in 2020. Despite these efforts, health system performance still lags behind other OECD countries, and beyond the aftermath of COVID-19, severe structural gaps in development levels face LAC-7 countries (see Chapter 3).

The 2018 Astana declaration renewed the commitment to comprehensive primary health care for all. To realise this aspiration, there is a need for strong political commitment and leadership to make primary health care the front door of the health system for everyone (Box 2.1). As emphasised in the next chapters of the report, strengthening primary health care will help increase preparedness and resilience of health system during health emergencies.

Box 2.1. Principles of Astana declaration

The global conference on Primary Health Care organised in October 2018 reaffirms the commitment to the Alma-Ata core principles towards the importance of building primary health care systems.

The Astana declaration defined primary health care services as “*high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed*”. An important component highlighted in the Astana declaration is the key role that primary health care can play in carrying-out public health functions, such as health promotion and surveillance, emergency preparedness, and response for health emergencies. During the COVID-19 pandemic, these strategies have all their relevance.

Source: Rasanathan and Evans (2020^[6]), Primary health care, the Declaration of Astana and COVID-19, <https://doi.org/10.2471/BLT.20.252932>, and Declaration of Astana. Geneva: World Health Organization; 2018. Available from: <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>.

OECD framework of high performing primary health care

A strong primary health care system, built on key attributes (people and community oriented, and providing comprehensive, continuous and co-ordinated care), increases preparedness and resilience during crises, including health emergencies. When primary health care services are the primary source of care to address the majority of patient needs, have appropriate information to assess a patient’s medical history, and are able to co-ordinate care effectively with other health services, they are well positioned to carry-out three core functions. These functions are:

- Primary prevention, especially providing health promotion and vaccination;
- Secondary prevention, including providing regular exams and screening to identify diseases; and
- Tertiary prevention, including delivering routine care for underlying health conditions.

Through its three core functions, primary health care provides a wide range of services ranging from health promotion, preventive, curative, rehabilitative and palliative health care services with the overarching objective of keeping population healthy and reducing disability or premature mortality.

These three core functions are critical to primary health care preparedness and resilience during crises (Box 2.2 for definition). Evidence confirms that most burdens related to health emergencies fall within the mandate of primary health care roles and functions (Burn et al., 2020^[7]; Matenge et al., 2021^[8]). This was the case in Australia and New Zealand, where general practices undertook a range of critical roles in providing responsive health care during several disasters that took place between 2009 and 2016. These roles included providing primary health care in alternative health care facilities, adapting existing health facilities for the purposes of providing disaster health care, and maintaining care continuity for management of chronic diseases. This was also evident during the COVID-19 pandemic in some OECD countries (OECD, forthcoming^[9]). In Belgium, Italy and Luxembourg, for example, primary health care teams played

a pivotal role in carrying out early and precise COVID-19 case detection in the community they operate and managing non-acute COVID-19 needs.

As such, strong primary health care is key to health systems absorbing and recovering from shocks. Indeed, there are many key linkages between core primary health care functions and the ability of countries to respond effectively to the COVID-19 pandemic or any other health emergencies (Figure 2.1). For example, primary health care has played an important part in COVID-19 vaccination rollout, informing patients and the community about COVID-19, contributing to early detection of COVID-19 and using outreach services to manage mild COVID-19 in community and primary care settings. Primary health care systems have also helped manage the burden of COVID-19, in co-operation with hospitals, to bring efficiency gains in containing viral spread and managing patients, while helping to avoid overcrowded hospitals. Primary health care had also a key role to play by ensuring that socially vulnerable populations have appropriate access to care during health emergencies. The community-based approach of primary health care, which implies deep knowledge of local context and local population, is crucial in this regards.

These core primary health care functions and linkages between non-health emergency and health emergency, with roles or responsibilities, are described in Figure 2.1.

Figure 2.1. Primary health care emergency preparedness and resilience framework: absorbing and recovering from a disease outbreak

Linkages between core PHC functions during non-health emergency and during health emergency

		During non health emergency Maternal and child health and non-communicable diseases	During health emergency Maternal and child health, non-communicable diseases + disease outbreak
<div> <div>People / community oriented ✓</div> <div>Continuous care ✓</div> <div>Comprehensive care ✓</div> <div>Coordinated care ✓</div> </div>	Core function 1 Primary prevention	Provide health promotion and routine vaccination	Maintain health promotion and routine vaccination <ul style="list-style-type: none"> + Informing and educating the community about disease outbreak + Identifying and reaching high risk population toward disease outbreak + Tracing of contact patients, and supervising quarantine + Vaccination for disease outbreak
	Core function 2 Secondary prevention	Provide regular exams and early detection of diseases	Maintain early detection of diseases <ul style="list-style-type: none"> + Passive and proactive testing for disease outbreak
	Core function 3 Tertiary prevention	Provide routine health care	Maintain routine health care <ul style="list-style-type: none"> + Manage disease outbreak related health conditions and its exacerbations + Empower patients to self-manage disease outbreak + Coordinate care and make appropriate referrals to hospital

Overall, strong PHC, which focuses on these three core functions, improves the overall health of the population prior to health emergency, which increase the capacity for individuals to protect their own health during a pandemic or any other future crisis. This enhances preparedness to deal with emerging pathogens or health shocks such as the COVID-19 pandemic. Embedding these three core functions into PHC also increases the resilience of health systems, by responding to both to diseases outbreak and non-disease outbreak needs during a health emergency. It helps reduce pressure on the entire health system.

Box 2.2. The NAEC resilience framework: System performance and resilience

Health systems need to build resilience and the ability to recover from and adapt to health shocks such as COVID-19. The New Approaches to Economic Challenges (NAEC) resilience framework considers four stages in a cycle of disruption:

- *Plan and prepare*: includes the steps taken by health organisations and related institutions to prepare critical functions and features of their operation for a universe of potential threats to avoid and mitigate disruptive events. This occurs prior to the disruption. For primary health care sector, in the case of a health shock, this involves upfront investments in public health, primary health care information systems, and primary care workforce.
- *Absorb*: comprises the capability of a system or organisation to absorb the consequences of an acute shock or extended stress without breaking and maintaining a certain degree of function. This involves limiting the extent of disruption and minimising the morbidity and mortality impact. During a pandemic, primary health can help absorb the shock by Informing and educating the community about COVID-19 to encourage compliance to infection control measures.
- *Recover*: during this phase, a system attempts to regain lost functions as quickly and efficiently as possible. Recovery also refers to the time and resources needed for the system to recover its functionality post-shock. Primary health care can for example contribute to recovery by carrying-out COVID-19 vaccination to minimise morbidity and mortality, and through early identification of cases and surveillance for deterioration of chronic conditions.
- *Adapt*: the capacity of an organisation or system to “learn” and improve its capacity to absorb and recover from shocks based upon past experience, reducing the impact of similar threats in the future. This informs the plan and preparation for the next cycle.

Source: OECD (forthcoming^[9]), *Ready for the Next Crisis? Investing in Resilient Health Systems*.

Core function 1: Ensuring primary prevention through health promotion and routine vaccination

People and community oriented primary health care is well suited to carry-out primary prevention through health promotion activities and routine vaccination to prevent the transmission of infectious-diseases and reduce the impact of a shock such as the COVID-19 pandemic.

During non-health emergency, primary health care works in concert with public health authorities to prevent diseases before it occurs. The overarching objective is to prevent exposure to risk factors that cause disease and to increase individual capacity to protect their own health. These includes a range of household and community measures, including health counselling on healthy behaviours (eating well, exercising regularly, not smoking, limiting alcohol consumption for example), health education on the prevention of infection, and also vaccination against infectious diseases.

During the COVID-19 pandemic, these translate into four key responses where primary health care has great potential for preventing transmission and reducing the impact of the pandemic:

- a) Informing and educating the community about COVID-19
- b) Identifying and reaching high risk population, the most vulnerable people
- c) Tracing contact patients to interrupt the chain of virus transmission and supervising quarantine
- d) Implementing COVID-19 vaccination
- e) Maintaining essential prevention activities

Primary health care can lead the efforts on informing and educating the community about COVID-19. Based on a community approach, primary care team can create awareness on COVID-19 risks, and tailor messages and information campaign on non-pharmaceutical intervention implemented in response to COVID-19 (such as mask wearing or social distancing). Depending on the local context in which primary care team operate, they can disseminate and reinforce public health messages on how to contain the spread of the virus including on infection prevention and control measures. In particular, primary health care team is best placed to identify and reach out their most vulnerable patients, who are at greater risk of being infected by COVID-19 such as patients with chronic conditions and multi-morbidity, elderly patients, or those with difficult living conditions.

In addition, contact tracing and quarantine are important tools to interrupt the chain of virus transmission. Once COVID-19 cases are identified (see core function 2), primary health care teams can facilitate contact tracing which enhances epidemiological surveillance. They can work with patients to trace contact before symptom onset to engage in backwards tracing. They can also help providing social and health assistance during quarantine as they have a good knowledge of local, health and living conditions in order to best meet patient's specific social and health needs.

Beyond this, primary health care teams have traditionally played a critical role in vaccine delivery including childhood and adult vaccination programmes (for example to prevent the spread of measles, diphtheria, tetanus toxoid and pertussis). Having a long history of delivering vaccination programme, primary care teams are uniquely placed to facilitate uptake and delivery of COVID-19 vaccines in the community, including for people living in deprived, rural and remote areas. Knowledge about medical and personal information of the local population, and long-time relationship with patients are key elements for successful and personalised vaccination rollout. As a trusted source of information, primary health care team can also provide immunisation counselling, counter vaccine hesitancy and misinformation. Recent evidence from high-income countries confirmed that the most important person in an individual's decision to get vaccinated is the primary care provider because he has the longitudinal relationship, understands their hesitation and can address them in a personal way (ACP Internist, 2021^[10]).

During health emergency, such as the COVID-19 pandemic, most health systems were overwhelmed. This resulted in essential health services being disrupted due to the high demand for intensive care, which can increase indirect mortality from other preventable and treatable conditions. Available evidence reveals that deaths due to malaria, HIV/AIDs and tuberculosis attributable to Ebola outbreak in 2014-15 was significant in low- and middle-income countries (Parpia et al., 2016^[11]). Maintaining essential health prevention activities, such as health promotion and immunisation for non-COVID-19, is critical to minimise excess indirect mortality due to health system failures.

Core Function 2: Providing secondary prevention, including providing regular exams and screening to identify diseases

As the first and main point of contact with the health care system, primary health care is best placed to detect disease at the early stage to halt its progress. Primary health care has an important impact on the stage at which a disease is diagnosed by performing clinical examinations and by recommending screening programmes to their patients (OECD, 2020^[11]). Beyond performing recommended and evidence-based clinical examinations, the role of the primary health care team can be significant in having a supportive and informative role to enable the early detection of disease. During non-health emergencies, these include regular exams and screening tests to detect disease in its earliest stage (mammograms to detect breast cancer for example). During public health emergencies, and when diagnostic capacity is insufficient, primary health care teams have a role to play by carrying-out COVID-19 detection.

Early detection of COVID-19 is key to minimise community circulation and maximise protection of vulnerable populations, including at risk populations such as the elderly, chronic patients, health care workers, or lower socio-economic groups. Primary health care teams have all the potential to participate

to early and precise case detection in the community they operate, through passive or proactive testing strategy. Passive testing strategy consists of symptomatic individuals self-present to a primary care facility for testing, while proactive testing strategy consists of programmes tailored to the unique needs of a population to offer a clear epidemiological picture. In both cases, when link to public health system, COVID-19 testing in primary and community care setting allow to collect information on COVID-19 cases to feed the surveillance system.

At the same time, it is important to recognise that early detection of non-COVID-19 diseases during the first phase of the pandemic was suspended or highly impacted to increase capacity for COVID-19 patients. Patients themselves have expressed concern about visiting health care facilities to do routine care or screening for fear of COVID-19 exposure. The result is that diagnosing of non-COVID-19 illness has been postponed while considered as essential health services under normal circumstances. Such delayed diagnoses will come at high costs for health systems, both human and financial. Less cancer screening for example will translate into worse outcomes when patients are diagnosed later in the course of the disease, making treatment more complex and more expensive, and reducing patient's survival. In the United Kingdom (England), diagnostic delays have been projected to increase five-year mortality for four types of cancer by about 5% (lung cancer) to 16% (colorectal cancers) (Maringe et al., 2020^[12]). Overall, between 3 291 to 3 621 lives could be lost due to four main cancers over the next 5 years due to delays in diagnosis caused by COVID-19 response. Accordingly, total years of life lost compared to pre-pandemic data for these cancers is estimated to range between 59 204 and 63 229. In Canada, cancer care disruptions during COVID-19 pandemic is estimated to lead to 21 247 more cancer deaths in Canada between 2020 to 2030, representing an increase of 2% in cancer deaths (Malagón et al., 2021^[13]). To minimise such indirect consequences, the capacity of primary health care needs to be maintained to make sure people have access to routine exams and other early detection services.

Core function 3: Providing tertiary prevention by delivering routine care for underlying health conditions

Continuous primary health care has a role to play to manage disease in the community to maintain people's health, avoiding complication or health deterioration. These include for example controlling the development of disease to reduce the morbidity and mortality attributable to disease, helping people manage long-term health problems and maintaining continuity of care for people post diagnosis. Care continuity and disease management in primary health care have been associated with greater patient satisfaction, improved medication adherence, lower hospitalisation rates and lower mortality (OECD, 2020^[1]; Pereira Gray et al., 2018^[2]).

During health emergencies, and given that COVID-19 has challenged health system capacity to respond, patients with mild or moderate COVID-19 can have access to primary health care to receive COVID-19 medical attention, performed some basic health checks, and receive patient education to manage their own health. For health systems, these entail the several priorities:

- Developing patient care pathways for both COVID-19 and for regular primary health care.
- Developing new primary health care facilities or transformed established facilities for mild and moderate COVID-19 patients.
- Empowering patients and family by educating them on disease control and the need for further medical attention.
- Monitoring the health situation of people isolated at home (home visit to check blood oxidation and other symptoms – giving particular attention to vulnerable people).
- Maintaining care continuity for those who need it to keep population healthy and reduce disability and premature mortality.
- Developing new protocol for long-COVID-19.

Maintaining routine care is essential for managing chronic conditions during health emergencies. Any care disruption for those patients will translate in rapid health deterioration and some health complications, leading to hospitalisation or deaths. The same is true for pregnant women who need essential prenatal care visits to ensure safe delivery. Maintaining continuity of care is also particularly important to vulnerable and marginalised populations, which are often disconnected from the health care system. Across OECD countries, more severe health outcomes due to delayed or missed care were found for people with chronic conditions, including Alzheimer's disease, dementia, diabetes, chronic obstructive pulmonary disease and anxiety. Among a panel of US Medicaid patients with chronic health conditions, mortality increased by 19 patients per 1 000 annually among those who have had high rates of delayed and missed care from 1 April 2020 to 31 December 2020 compared to the same period in 2019 (Smith et al., 2022^[14]). Maintaining routine health care delivery for non-outbreak diseases during health emergencies will help mitigating health deterioration, and minimise the long-term consequences of the COVID-19 pandemic.

Methodology

Countries covered in the report

This report compares seven Latin American countries (LAC). Four LAC countries are OECD member states (Chile, Colombia, Costa Rica and Mexico), and three LAC countries are partner countries to the OECD (Argentina, Brazil and Peru). In 2022, the OECD invited Argentina, Brazil and Peru to become OECD Members.

These seven LAC countries are referred as *LAC-7* countries throughout the publication. Some averages may refer to all 33 countries of the LAC region and accordingly, the classification *LAC-33* is used to refer to the average for the 33 LAC countries. Depending on the country coverage, the classification of the average is adapted to reflect the total amount of countries for which data is available. This same methodology applies for OECD averages when data are not available for all 38 member countries.

Selection and presentation of indicators to measure primary health care performance

The indicators have been selected on the basis of being relevant to monitoring primary health care performance, taking into account the availability and comparability of existing data in the LAC Region. The indicators are presented in the form of easy-to-read figures, backed by available evidence from the literature and qualitative information taken from a policy survey conducted by the OECD. The objective of the policy survey was to identify the most relevant actions and policies that primary health care in LAC-7 countries have developed to control the COVID-19 pandemic. The areas covered in the policy survey included for example the use of personal protective equipment (PPE), testing for COVID-19, co-ordination between primary health care and public health for disease surveillance, managing COVID-19 cases and ensuring care continuity, supporting PHC workers, and implementing vaccination against COVID-19.

Due to the exceptionality of 2020 and 2021 following the COVID-19 pandemic and its impact on the health system as a whole, most of the analyses presented in the following chapters focus on 2019 figures. In addition, 2019 data is also preferred as not all LAC-7 countries have 2020 data available, hindering inter-country comparability when contrasting some countries at a pre-COVID-19 level with others in a post-shock setting. Table 1 present the list of quantitative indicators used, sources, and years of data throughout Chapters 4, 5, and 6 of the publication, covering the three core functions presented in Figure 2.1.

Table 2.1. List of indicators to assess the performance of primary health care

Core function	Indicators	Source	Year
Core function 1 Ensuring primary prevention through health promotion and routine vaccination	Infants exclusively breastfed – first 6 months of life	UNICEF 2021	2020, or latest year available
	Feeding practices after six months of age	DHS and MICS surveys, various years; UNICEF Infant and young child feeding	Latest year available
	Contraceptive prevalence by socio-economic characteristics, any method, selected countries, latest available estimate	DHS and MICS surveys, various years	Latest year available
	Demand for family planning satisfied by socio-economic characteristics, any method, selected countries, latest available estimate	DHS and MICS surveys, various years	Latest year available
	Vaccination rates for diphtheria, tetanus toxoid, and pertussis (DTP3) and measles, children aged around one	OECD Health Statistics 2022, WHO GHO 2021	2019
	Vaccination coverage by socio-economic characteristics, selected countries, latest available estimate	DHS and MICS surveys, various years	Latest year available
	Proportion on primary health care team using EHR	OECD Survey of Electronic Health Record System Development and Use, 2016 and 2021, and available evidence	2021, or latest year)
	Public health activities carried-out by PHC during the COVID-19 pandemic in LAC-7 countries	OECD Policy Survey on the role of primary health care during the COVID-19 pandemic	2021
	COVID-19 immunisation in the region	Our World in Data 2022	2021-22
Core function 2 Ensuring secondary prevention, including providing regular exams and screening to identify diseases	Main causes of mortality in LAC-7 and the OECD	The global health observatory, WHO	2019
	Mortality burden of cancer in LAC-7 and the OECD	The global health observatory, WHO	2019
	Breast Cancer screening coverage	Costa Rica & Brazil from Brazil Primary Health Care Review, OECD 2021. Mexico, Chile, OECD from OECD.stat. Colombia from INC 2019. Peru from Hernández-Vásquez and Chacón-Torrico, 2019.	2019
	Cervical Cancer screening coverage	Costa Rica & Brazil from Brazil Primary Health Care Review, OECD 2021. Mexico, Chile, OECD from OECD.stat. Colombia from INC 2019	2019
	Antenatal consultations	UNICEF global databases, 2021, of antenatal care, based on MICS, DHS, and other nationally representative household survey data.	2015-20
	Mammography Units	Several sources, please refer to Figure 5.6	Latest available year
	Computed tomography scanners	OECD 2019 for MEX, BRA, CHL, COL and OECD34, others from GHO, WHO 2019. CRI from HaG LAC 2020.	Latest available year
	Magnetic resonance imaging (MRI)	OECD 2022 for MEX, BRA, CHL and COL, others from GHO, WHO. CRI data from HaG LAC 2020.	Latest available year

Core function	Indicators	Source	Year
	LAC-7 countries leveraged PHC to carry-out COVID-19 detection in the community	OECD Policy Survey on the role of primary health care during the COVID-19 pandemic	2021
	% Reduction in coverage rates of screening and early detection services in 2020 compared to 2019	For Mexico, Doubova et al., 2021, For Chile DEIS – Ministerio de Salud Chile, 2022; OECD, 2022; for Peru BPT, GOPBM – MINSA, 2021; Maternal Health – Roundtable for Concertation and Fight against Poverty, 2021.	2019-20
	Proportion of disrupted services. LAC-7 country responses. Services related to screening and early detection.	WHO 2022	2021
	Disruption of cervical cancer screening during the COVID-19 pandemic	OECD 2022	2020
Core function 3 Providing tertiary prevention by delivering routine care for underlying health conditions	Avoidable hospital admissions	OECD Health Statistics 2022	2019, or latest available year
	Breast cancer 5-year net survival (%), adults (15-99 years)	BRA, CHI, COL and CRI from OECD Health Statistics 2022, others from CONCORDE-3	Latest available year
	Colon cancer 5-year survival rate (%), adults (15-99 years)	BRA, CHI, COL and CRI from OECD Health Statistics 2022, others from CONCORDE-3	Latest available year
	Antibiotics consumption	2022 OECD Health Statistics for OECD average, Chile, and Costa Rica. WHO antibiotics report for the other countries.	2019, or latest available year
	Average proportion of infections caused by bacteria resistant to antimicrobial treatment for eight antibiotic-bacterium combinations	Stemming the Superbug Tide: Just A Few Dollars More, OECD 2018	2005, 2010 and 2030 projections
	Antiretroviral therapy coverage for people living with HIV (%)	WHO 2020	Latest available year
	Patient experience measures such as communication with the PHC provider	<i>Desde el paciente: Experiencias de la atención primaria de salud en América Latina y el Caribe</i> , Guanais et al., 2019	Latest available year
	Primary health care in LAC-7 countries has managed mild-COVID-19 care needs in the community	OECD Policy Survey on the role of primary health care during the COVID-19 pandemic, OECD 2021	2021
	Changes in patient admissions between 2015-19 average and 2020 by health care provider in Chile	Chile Health Superintendence 2022	2020
	Reduction in consultations for hypertension and diabetes from 2019 to 2020 in LAC-4 countries (%)	Arsenault, 2022 for CHL and MEX; INEI, 2021 for PER; CRI from CCSS, 2020	2019-20
	Expansion of the role of non-physician primary health care workers to manage COVID-19 and maintain care continuity	OECD Project on the Resilience of Health Systems Questionnaire, 2022	2022

Structure of the report

The report is divided into seven chapters. Chapters 1 and 2 presents the key findings and the conceptual framework used for Chapters 3 to 5 of the report. The key findings provide a high-level overview of the performance of primary health care in LAC-7 countries, as compared to the OECD average, and summarise the main findings of the publication to improve preparedness and resilience during health emergencies through stronger primary health care.

Chapter 3 on **Main features and challenges of LAC countries health systems** provides an overview of the organisation of health systems and primary health care systems in LAC-7 countries. It gives an overview of LAC-7 socio-economic characteristics, explores the organisational structure and the main stakeholders of each country's health system, and presents the main health challenges faced by each country's population.

Chapter 4 on **Health promotion and vaccination** explores primary health care performance before COVID-19 on health promotion and routine vaccination in LAC-7 countries, looking at the promotion of child and maternal health, counselling for risk factors for health, and routine vaccination programmes. The chapter also analyses the public health activities that have been scaled up into primary health care in LAC-7 countries during the COVID-19 pandemic.

Chapter 5 on **Screening and early detection of diseases** explores the performance of PHC in LAC-7 countries concerning screening and early detection of disease before and during the COVID-19 pandemic. The chapter also reviews the impact of the COVID-19 pandemic on screening and early detection of other diseases.

Chapter 6 on **Routine care for underlying health conditions** examines the third core function of primary health care, which is about managing disease in the community to help reduce morbidity and mortality, while maintaining continuity of care for all during a health emergency.

Chapter 7 on **Investments in health workforce** provides a review of the ways in which LAC-7 countries assess their current and future health workforce needs to help inform investment decisions to strengthen health workforce capacity. The chapter also assesses the human resources for health needs in LAC-7 countries.

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