IFMSA Policy Document
Primary Health Care

Proposed by the Team of Officials
Adopted at the IFMSA General Assembly August Meeting 2019, in Taipei, Taiwan.

Policy Statement

Introduction:

Primary Healthcare (PHC) is an approach to healthcare provision centred on the needs and circumstances of individuals, families and communities. It addresses comprehensive and interrelated physical, mental and social health and wellbeing, while covering a breadth of services that include prevention, treatment, rehabilitation, and palliative care. It is described by the World Health Organisation (WHO) as being "usually the first point of contact people have with the healthcare system. It provides comprehensive, accessible, community-based care that meets the health needs of individuals throughout their life."

IFMSA Position:

The IFMSA affirms that PHC is vital to all health systems around the globe and plays a crucial role towards achieving Universal Health Coverage (UHC), as well as the 2030 Sustainable Development Goals. The IFMSA also strongly supports investing in strong PHC systems, which are built on multidisciplinarity and the collaboration among all allied health professionals. IFMSA recognises the importance of active participation of communities and vulnerable groups in shaping the PHC services in their local communities. This can greatly enhance the health status and wellbeing of the population, while leading to their increased productivity. PHC should also be integrated in medical and health professions' education from an early undergraduate level, and governments should support medical graduates to establish fulfilling careers in PHC. Last but not least, the IFMSA affirms that all health workforce employed in PHC ought to enjoy fair working conditions, with appropriate remuneration and career advancement opportunities.

Call to Action:

The IFMSA calls on Governments to:

- Invest in the seven building blocks of the health system: service delivery, health workforce, health information systems, access to essential medicines, financing, leadership, and governance.
- Increase funding in local, provincial and national budgets to strengthen and build capacity of the health workforce for PHC services.
- Offer family support for workers in rural areas to help with retention of the PHC workforce, such as access to day care services, opportunities for free schooling and transportation assistance.
- Increase funding and investment in programs focusing on empowerment and involvement of communities and vulnerable groups to ensure their active participation in shaping PHC services in their local communities.
- Recognise and address the social determinants of health, such as housing, employment, sanitation among others and identify support mechanisms that could be provided in a PHC setting.

- Ensure equitable access to PHC services, particularly addressing the significant health disadvantage experienced by those of lower socio-economic status and those in remote communities.
- Fast-track the development and implementation of policies on PHC to facilitate infrastructure development and provide a broader framework for the realisation of health goals in a country.
- Support and encourage medical schools to incorporate primary health education and training into their curricula and support relevant research.
- Create partnerships with NGOs, civil society organisations, private sector, academia, patient groups and vulnerable communities to strengthen primary health care service delivery locally and nationally.
- Meaningfully engage youth and young health professionals in policy and programmes design, implementation, monitoring and evaluation for PHC.
- Support and invest in the use of technology to improve access to health care, enrich health service delivery, improve the quality of services and patient's safety, and increase the efficiency and coordination of care.
- Recognise the efficiency, both in financial and health improving terms, of offering appropriate health services in a primary, community setting and make the provision of services in the community a priority, where possible.

The IFMSA calls on International Health-related Organisations to:

- Continue to encourage Member States to invest in PHC services at a grassroots level.
- Promote the vision and commitments in the Declaration of Astana.
- Enhance institutional capacity and leadership across WHO country offices to support Member States in strengthening PHC at national level.
- Monitor PHC indicators to track progress of Member States consistently, with a regular proposed cycle. Report progress publicly in order to inform future planning and implementing of PHC initiatives.
- Continue to provide opportunities and maintain adequate youth engagement in promoting PHC.

The IFMSA calls on Medical Schools and Academic Institutions to:

- Ensure that PHC principles, such as health promotion and disease prevention, are included during medical education and form a mandatory component of each school's curriculum.
- Engage medical students in quality PHC placements as part of their core curricula.
- Encourage all medical students to pursue General Practice/Family Medicine careers, by providing strong mentorship initiatives, connecting students to communities (e.g. through outreach programmes) and offering high quality PHC placements.
- Ensure the next generation of healthcare providers are up to date with family planning and disease control.
- Expand their teaching settings beyond university hospitals, by incorporating rural and remote health center placements and ensure medical students are provided with adequate undergraduate training in resource-constrained settings and exposure, early on.
- Offer scholarships and/or support to students with commitment to work in rural PHC upon graduation.
- Facilitate interdisciplinary collaboration across health disciplines to reflect the provision of holistic care to patients.

The IFMSA calls on its National Member Organisations (NMOs) and on young health professionals to:

- Actively advocate for PHC, by engaging in policy formulation and collaborating at all levels, from local to global and for PHC and community-based education in the medical curriculum.
- Promote interprofessional and intersectoral collaboration, and exchanging of expertise and ideas, to upskill young health professionals/students and provide multi-dimensional knowledge in the PHC sector

- Collaborate with PHC departments to set up exchanges for students, using the IFMSA exchanges platform.
- Develop projects and resource toolkits that raise awareness and build capacity in the field of PHC.
- Engage in research involving PHC and share best practices on open-access platforms.

The IFMSA calls on other relevant partners and stakeholders to:

- Create public-private partnerships for health promotion & disease prevention programmes.
- Ensure workers are enrolling in continuous professional development courses to stay up-to-date with PHC related developments.

Position Paper

Background Information:

When healthcare experts refer to primary health care (PHC), they typically make reference to the Alma Ata Declaration that committed 134 member states to supporting PHC as a policy to achieve health goals. PHC was grounded in concerns for social justice and human rights following the end of the Second World War, as it was built on the principles of equity in access to health services and the right for one to participate in decisions about their own healthcare.
The Alma Ata Declaration was produced following the International Conference on Primary Health Care convened by the World Health Organisation (WHO) in Alma-Ata, USSR from the 6th to the12th of September 1978. The definition of PHC as outlined in the Alma Ata Declaration states that:

"*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 at 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*."

PHC forms an integral part both of the country's health system, of which it is the first level of contact and it ought to be its central function and main focus, and of the overall social and economic development of the community. [1]

As part of their efforts, the WHO has developed a cohesive definition of primary health care briefly based on three components:

- Ensuring people's health problems are addressed through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritising key system functions aimed at individuals and families and the population as the central elements of integrated service delivery across all levels of care.
- Systematically addressing the broader determinants of health through evidence-informed public policies and actions across all sectors.
- Empowering individuals, families, and communities to optimise their health, as advocates for policies that promote and protect health and wellbeing, as co-developers of health and social services through their participation, and as self-carers and care-givers to others. [2]

According to the WHO, there are five key concepts associated with delivering PHC: (1) providing first contact of care for new health problems, (2) comprehensive care for most health problems, (3) continuity of care, (4) long-term person-focused care and (5) care coordination. [3] The public health functions that are specifically relevant to a PHC approach and are closely linked to primary health care are health promotion, health protection, and disease prevention (service delivery), surveillance and response, and emergency preparedness (intelligence).

While we have made great strides in health outcomes globally over the past 40 years, we face many ongoing challenges. PHC development has been unequal across the world. This is often due to a combination of under investment, lack of political will and misconceptions about the role and benefits of PHC, . However, PHC remains the most effective way to sustainably solve today's health problems and health system challenges, achieve UHC and the health-related Sustainable Development Goals (SDGs) and so, on 25-26th October 2018, the world came together in Astana, Kazakhstan, at the Global Conference on Primary Health Care to renew its commitment to it. [4] The Astana Declaration called for member states to commit in four key areas: (1) make bold political choices for health across all sectors; (2) build sustainable primary health care; (3) empower individuals and communities; and (4) align stakeholder support to national policies, strategies and plans.

Discussion:

Why is PHC important for the attainment of UHC?

PHC is an essential part of people-centred health systems and vital to working towards UHC [4] , being the most efficient and cost effective way to achieve universal health coverage around the world. Due to the broad impact of PHC as a first point of health for the general population, a comprehensive system of PHC can contribute positively to attainment of UHC for everyone. [5]

The WHO measures UHC attainment at a national level using tracer indicators.[6] Most of these indicators, such as childhood immunisation, cervical cancer screening and tobacco cessation programmes are provided for by PHC services rather than in a hospital setting. Therefore, for governments striving to achieve UHC for their people, PHC is the most cost-effective, strategic system for ensuring equitable health for all.

Who provides PHC?

The PHC workforce includes an array of skilled individuals that work together as a multi-disciplinary team to provide comprehensive care for communities. These include, but are not limited to, family physicians, otherwise known as general practitioners (GPs), community-based nurses, physiotherapists, occupational therapists, dieticians, social workers and psychologists. [7]

Though the optimal number of different types of health workers varies from context to context, there is nevertheless a correlation between the availability of health workers and provision of health services. For essential primary health care services, a minimum number of health workers is required to attain and maintain primary health care services of acceptable quality. For example, according to the UNHCR, PHC requires 22 qualified HWs, 1 clinician, 1 nurse, 1 midwife and 1 CHWs for every 10000 people in addition to 1 qualified laboratory staff, 1 pharmacist, 1 full-time mental health staff and 1 medical doctor as a long term standard PHC staffing. [8]

Rural PHC is usually delivered through periodic team outreach days and/or telemedicine. Nurses are thought to have a vital role in providing a large proportion of PHC - with many physician tasks now shifting to nursing staff - such as immunisation and cervical cancer screening - which saves not only time, but costs as well. [7][9]

Rural primary health care and challenges

While PHC in 'rural areas' does not have a standard definition, the phrase refers to low population density and/or a large geographic distance from hospitals [9]. The WONCA Working Party on Rural Practice (RuralWonca), a global network of rural family doctors and academics, published a rural PHC Education Manual in 2016 [10] which is divided into 5 themes including (1) framing and resourcing of

rural medical education and practice, (2) medical education in rural settings, (3) professional and technical support for rural medical education, (4) undergraduate medical education and (5) postgraduate medical education thus offering academic institutions and teachers alike the much needed guidance in developing and contextualising rural health education.

There has been, and still to this day, a shortage of rural PHC worldwide. Remote areas find it difficult to recruit and retain doctors and allied health professionals, while funding and resources are often scarce. A large proportion of rural PHC's purpose is to provide preventative services such as immunisations, screening for STIs and cancers, and health promotion, rather than downstream services which are better suited to tertiary-level hospitals. Despite that, rural physicians are still required to be well trained in medical and surgical emergencies- which ultimately requires specialised postgraduate training.

To address the workforce shortage in rural settings, multiple studies have shown that medical schools which include clinical and educational experiences in rural settings encourage a future interest in a rural PHC career [11][12][13][14]

Telemedicine has become very useful to rural populations, especially those in impoverished settings, as it is a cost-effective method for physicians to do consultations [15], which is visited in a later part of this policy document as well.

Drones are also effective in rural settings- such as for delivery of medicines and blood, and collection of clinical specimens for testing [16][17][18].

Investing in community-based laboratories, rapid diagnostic tests, imaging and diagnostic tools would be helpful in rural areas, to reduce transport and hospitalisation costs for illnesses that could be diagnosed in the community with proper tools. [19][20][21]

The Role of PHC at supporting disadvantaged populations

Disadvantaged populations have a proven difficult time accessing health services they need. Health Canada listed 14 social determinants of health, ranging from education level to gender, that plays a significant factor into the health outcomes of a patient [22]. Research has shown that these non-medical factors play a much larger role in determining how much an individual suffers from ailments than any biological predisposition [23]. There are three targeted populations that are better served by primary physicians: those with low literacy, low socioeconomic status, and the elderly.

Primary care doctors offer longitudinal care to their patients and have better insight into patient personalities and the unique barriers faced by each patient. These physicians can integrate their medical knowledge with their understanding of the individual patient to provide the most appropriate treatment plan that is most accessible and practical to the individual. Through understanding the needs of patients with low literacy, physicians can provide appropriate treatments and become informed advocates for their equal access to services. Physicians also have access to resources that can be beneficial to patients of low socioeconomic status [24]. In addition, primary care doctors play an important gatekeeper role serving an important bridge to access to secondary and tertiary services, by screening for diseases and directing patients to the relevant departments. As the median age of the global population increases, older patients are faced with multiple complex comorbidities which requires management by multiple specialists. Primary care physicians can serve as the important link of communication between specialists and the patient. They monitor for negative effects from polypharmacy and effectively coordinate all of the patient's appointments, lab tests, and results to prevent information from falling in between the cracks.

What is the economic value of Primary Health Care?

Traditionally, PHC has focused on education and health campaigns, as part of a strategy to address the diseases of interest in public health. As many of these problems still remain in the public health

agenda, it is urgent to review the concept of PHC. It is necessary to consider primary health care as a strategy of high impact, and to stop looking at it as a series of low-cost activities, limited to the services provided by promoters and volunteers, with low complexity technologies to serve the poor. [25]

Existing evidence shows that investing in primary care can reduce overall health costs and the use of secondary care. Primary-care doctors use fewer resources in terms of hospitalisations, prescriptions, tests and procedures compared to other health specialists. As primary health care improves life expectancy and reduces mortality, it provides economic benefits as well as obvious value for health. The return on investment from community health workers (CHWs) has been estimated as $10 for every $1 spent in sub-Saharan Africa. In addition, there is compelling evidence of significant economic benefit from the provision of preventive services in PHC; for example, the return on investment from childhood immunisations in LMIC has been estimated as $44 for each $1 spent [3].

The Scoping review titled “Building the economic case for PHC” published by the WHO also offers powerful proof linking PHC to improved health outcomes, health system efficiency and health equity and encouraging further investment in PHC [3].

Thus, the PHC strategy could be the strategy that succeeds integrating private and social interests, by achieving that the earnings of prevention contribute to the economic sustainability and the improving of health conditions for the population in general.

How can governments address the PHC workforce shortage?

To meet the health workforce requirements of the SDGs and UHC targets, over 18 million additional health workers are needed by 2030 globally, according to the 2016 United Nations High Level Commission for Health Employment and Economic Growth (COMHEEG) report. Gaps in the supply of and demand for health workers are concentrated in low- and lower-middle-income countries. According to the same report, the growing demand for health workers is projected to generate 40 million health sector jobs to the global economy by 2030. To address these shortages, investments are needed from both public and private sectors in health professions education, as well as in the creation and filling of funded positions in the health sector and the health economy. [10]

Experts say that there are several reasons the governments’ efforts to increase the ranks of new physicians in PHC and family practice are being hampered. Medical students often carry increasingly unmanageable student debts, leading them to select higher-earning specialties rather than Family Medicine. Reports show that the average medical students’ debt has increased by 6.3% every year since 1992. Unsurprisingly, in the same AAMC report, 47.5% medical students were found to be heavily influenced in their specialty choice by income expectations and 27% were influenced by their student loan debt. [27]

A potential initiative that governments could develop to tackle these reasonable concerns would be to cover loans for students who pursue training in primary care, offer scholarships for young doctors training in primary care or ultimately, increase remuneration for primary care physicians and rural practitioners.

How can medical schools address the PHC workforce shortage?

Medical schools in some countries still encourage specialisation and PHC is often perceived as a specialty that is not high-paying compared to other competitive specialties (which can also remain true in many cases). This highlights the need to change the culture through promotion of PHC and Family Medicine as a career. [25]

The most successful primary-care training programs identify students who already know they want to be primary-care physicians when they start medical school. Those showing the most interest often come from rural communities themselves, which can also be a consideration during admission processes in areas with need for rural practitioners. [11][13]

Training more physicians is not enough; a multi-pronged approach is necessary to ease the physician shortage. Medical schools and teaching hospitals are educating future physicians in team-based, interprofessional care, developing innovative care delivery and payment models, and integrating cutting-edge technology and research into the patient care environment. Legislation that would increase federal support for an additional 3,000 new residency positions each year over the next five years is also a pathway to be considered. These additional slots are crucial since every medical school graduate needs to complete training after medical school to practice independently. [23]

Federal incentives and programs such as the National Health Service Corps, Public Service Loan Forgiveness and the Conrad 30 Waiver Program present in the US should be supported and elevated since they are designed to recruit a diverse workforce and encourage physicians to enter shortage specialties and practice in underserved communities. [23]

In simple words, a multi-sectoral approach with fully engaged stakeholders is needed when implementing PHC workforce recruitment and retention strategies.

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How can health & information technology serve Primary Health Care?

In an ever changing world, where technology advancements happen between seconds, the discussion on how Information Technology can support PHC must be held. Governments need to invest in developing innovative solutions that make use of up to date resources, using technology for the benefit of the health provider and the patient alike. However, the cost associated with such movements can be high; yet, the returns can be higher. Diseases which pose a great burden in health care systems, such as tuberculosis, can benefit from technology in a primary care setting, e.g. through the use of geo-referencing systems or the use of home delivery treatment or e-monitoring among others. The main goal of PHC ought to be prevention, however timely diagnosis and appropriate treatment are the basis upon which successful PHC is built. [25]

It must also be noted that to overcome challenges we require Information and Communications Technology (ICT) that can support, enhance and accelerate primary health care professional education and medical practice [28]. ICT is an effective means of developing workforce capacity. It contributes to overcoming geographical barriers and substantially increasing health care professionals' access to postgraduate education without the need for travel. Eventually, this helps to avoid disruption in healthcare and aids in recruiting and retaining professionals.

A prominent advantage is indeed cost-saving. Traditional models of health professional education as well as the documentation and archiving systems in any healthcare facility are expensive, strenuous and tedious, both for the provider and the health care professional. Developing ICT solutions may entail high initial costs but these are reduced over time, and with more users, achieve economies of scale. Electronic medical records (EMRs) should be welcomed in primary care.

The call is urgent to invest in research for the development of technologies and interventions that bring the health system to the population; to train professionals capable of leading a primary, innovative and sustainable care; to make use of research results in the design of programs in health, so that they integrate interventions of proven cost-effectiveness; and to formulate health policies with continuity based on PHC, as a strategy allied to institutions and the system, in a general sense. Only that way, will the universal right to health services-enacted for so long- become real.

Therefore, the IFMSA accentuates the importance of moving forward with PHC in the current landscape of technological advancements. [29]

The future of primary care

The health system shift from a traditional medical model to a primary care model is becoming increasingly favourable, especially in rural and impoverished settings, as PHC encompasses a holistic multidisciplinary approach to healthcare as well as addressing disease prevention and health promotion. With a surge in chronic conditions and an increasing life expectancy, the world is becoming ever more dependent on PHC. Come the year 2030, it is expected that many countries will be realising the benefits of primary healthcare. A strong PHC foundation is vital for the attainment of UHC to meet basic health needs for all, SDG 3. PHC success requires all of the aforementioned conditions, including a strong workforce, investment in technologies, expanded rural community care, and an intersection with public health services [30, 31].

Introducing youth and young professionals into the PHC workforce is crucial [32]. For medical schools and governments to successfully promote PHC careers for the young health workforce, they should ideally introduce them early on in their training to community care, rather than restricting their training to the hospital environment and narrow focus on the biological aspects of the diseases. Offering training in PHC will allow students to understand the particularities, demands and limitations of the societies that determine health outcomes, as well as the understanding of the physical, biological, psychological, socioeconomic, environmental, cultural and political determinants of the health-disease process.

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