GENPRO
General Practice Owners Association of Aotearoa New Zealand

9 December 2021

Committee Secretariat
Pae Ora Legislation Committee
Parliament Buildings
Wellington

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Tēnā koutou

Pae Ora (Healthy Futures) Bill

Thank you for the opportunity to comment on the Pae Ora (Healthy Futures) Bill.

GenPro is a national not-for-profit membership association representing the contracted providers of general practice and urgent care centres across New Zealand.

I am pleased to provide the attached submission on behalf of GenPro members who provide essential front-line, first-contact services to local communities in every region from the Far North to Southland. This submission has been developed with their full engagement.

To support this submission, I would be happy to present oral evidence to the Committee or provide additional information or clarification where this would aid the points we have made.

I hope that this submission is helpful and I would wish you well with your refinement of the Bill.

Nāku, nā

Dr Tim Malloy
Chair

enc.

A. About GenPro:

GenPro is a not-for-profit, membership Association representing the contracted providers of general practice and urgent care centres. It is the only such national representative association with a direct mandate from its members. GenPro's Mission is to promote and advocate for sustainable, responsive and high-quality general practice services for the population of New Zealand.

GenPro also leads the secretariat and co-leads the representation for ALL contracted providers (whether GenPro members or not) through the Contracted Provider Caucus at the national PHO Services Agreement Protocol (PSAAP) Group – the national forum where the Ministry, DHBs, PHOs and Contracted Providers agree the annual PHO Service Agreements and Back-to-Back contracts with each general practice contracted provider.

B. Structural Reform:

GenPro notes, in the general policy statement supporting the Bill, the reference to the Health and Disability System Review (H&DSR) which described a system that had become fragmented and complex, leading to unclear roles, duplication, mis-alignment, and a lack of a common whole-system ethos. GenPro broadly agrees with this conclusion but also notes that New Zealand has an enrolment-based general practice/primary care system that is the envy of many across the world.

The general policy statement advises that tackling these issues requires reform that fundamentally changes the structure and accountability of the publicly-funded system. However, GenPro notes that the H&DSR also clearly stated that the system is significantly underfunded – which supports GenPro's belief that the single most important factor that will improve health outcomes for New Zealanders is the correction of the underfunding of front-line health services.

GenPro would urge caution to avoid repeating the mistakes of many previous structural health reform programmes across the world:

- Structural reform, will not, in itself, provide more front-line services or more front-line health professionals or greater access to essential health services and will not, therefore, improve health outcomes for New Zealanders.
- The current structural reform programme, which appears already underway, raises concerns that contrary to supporting improvements in front-line services for patients, actually appears to be diverting hundreds of millions of dollars of much needed funding away from front-line services.
- Structural reform can result in system paralysis for several years and there is evidence that this is already happening (e.g. At a meeting of PSAAP in November 2021, DHB representatives stated they were unable to make some decisions because they "won't be here soon" and Ministry of Health officials stated they were unable to make some decisions because the Transition Unit had taken on many of their responsibilities).
- Structural Reform must not just rearrange the deck chairs and result in the same arrangements under different organisation names (e.g. GenPro is concerned at the commitment already given to transfer all DHB staff as at 1 July 2022 on existing terms and conditions to Health NZ and believes that this is unlikely to support change).

GenPro believes that clearly defined governance, accountability and leadership arrangements are important and should not be duplicated or undermined. In that regard GenPro is concerned that the establishment of Health New Zealand and the Māori Health Authority alongside the Ministry of Health has significant potential to increase duplication, fragmentation and mis-alignment rather than the intended objectives of reducing such issues.

Conversely, the proposed development of the Government Policy Statement on Health and, the longer-term New Zealand Health Strategy would appear to offer a significant opportunity for cross-party collaboration and agreement which could enable a truly longer-term and apolitical approach to health planning for the people of New Zealand. GenPro would strongly support such an approach and believes the benefits would be significant.

C. Service Model:

GenPro believes that the reform programme and structural arrangements should directly support service delivery for the population. In that regard, GenPro would urge that the reform arrangements explicitly support:

- Nationally consistent service specifications to avoid increasing inequity and the continuing postcode lottery of health services. Where necessary (e.g. Rural) there should be local flexibility in service delivery arrangements (without changing the nationally consistent service specification).
- Service specifications and resources should support a broader and more integrated primary care service offering which is hosted or clinically co-ordinated through the already proven, list-based general practice (which includes the various definitions such as healthcare home, neighbourhood health home etc).
- Services should be developed through a genuine co-design and engagement process as part of effective and best-practice change management (GenPro notes that, as with recent COVID service developments, New Zealand's health service design and costing appears to now occur behind closed doors and then imposed on providers and consumers – which has resulted in unintended service gaps, underfunding and lack of buy-in from many stakeholders).
- Services must be underpinned by nationally consistent IT and data infrastructure.
- Re-design of care pathways, such as the transfer of hospital-based services to primary/community settings, should adopt the same principles set out above (e.g. nationally consistent, proactive co-design).
- Front-line service provision should be supported by "facilitation" through Localities to include ensuring prompt and appropriate access to services across the wider determinants of health and social care.

D. Workforce:

It is well documented that front-line workforce shortages are significantly impacting upon access to, and quality of services – and the workforce challenges show no sign of improving. GenPro would urge that the reform programme directly delivers:

- Permanent and funded solutions to workforce shortages – especially GPs and nurses (e.g. more training places).

- The training, development and funding of new health professionals as an addition to the existing workforce (e.g. Nurse Practitioners and health coaches should not be an alternative to more GPs, they should be in addition to).
- Reinstating general practice as the career of choice for medical graduates, through:
    - Increased training places
    - Increased funding for Registrars in general practice (should be at least comparable to secondary care)
    - Pay parity with secondary care (The Director General of Health recently acknowledged this issue, saying "*I agree – it is one of the biggest inequities in our system – the pay differential between hospital employed or DHB employed specialists and primary care-based specialists."*)

E. Localities:

GenPro notes the proposed development of Localities and believes that more detail is required with regards to their proposed purpose and functions. In this regard, attached at Appendix A to this submission is a copy of GenPro's submission of 29 July 2021 to the [Health Reform] Transition Unit to help inform the development of Localities.

GenPro would specifically suggest that:

- Function should come before form (GenPro is concerned, for example, that approximately $40m is being committed into structural prototypes before there is clarity around their purpose and functions).
- Whilst it has been stated that Health NZ will have responsibility for setting "Locality Plans" to support the National Health Plan, there are again questions about the role of Localities - but GenPro believes there is a potential facilitation role to enable access to services to support the wider determinants of health and wellbeing services.
- Localities must not duplicate or add extra layers of administration or reduce resources for front-line services by "clipping the ticket" (Localities must learn from the mistakes of PHOs).
- Localities must not add bureaucracy which detracts time or resources from service providers or the delivery of services.
- Localities must not be allowed to compete for services or with providers (GenPro would want to specifically ensure that conflicts of interest are not repeated – e.g. Many PHOs have purchased general practice providers using accumulated reserves and may have then subsidised unfair competition – using funds that should have originally supported the neighbouring, and original, general practices).

F. Contracting:

GenPro supports the continuation of the hybrid public-private health system model that ensures patients benefit from a public funded system operating alongside private providers delivering publicly-funded or publicly-subsidised services (e.g. general practice and much of primary care).

The public and system-wide benefits delivered by private providers (within the public system) are significantly under-recognised. These include factors such as significant capital investment, goodwill and innovation.

Similarly, the benefits of list-based primary care are also often under-recognised within New Zealand whilst admired by many jurisdictions and experts worldwide – including the World Health Organisation, whose 1978 Declaration of Alma-Ata and subsequent 2018 Astana Declaration on Primary Health Care has been committed to by over 150 countries worldwide – the 2018 Astana Declaration is set out in Appendix B to this submission.

GenPro would therefore urge the Committee to recognise the patient and system benefits of the private sector (including charitable community trust-owned general practice providing essential services in otherwise underserved remote and rural communities) within the publicly funded system. In doing so, GenPro would specifically suggest that:

- The system reforms, and publicly-funded contracting with proven private sector providers should be based within a high trust, low bureaucracy environment.
- There should be nationally consistent service standards with local flexibility on delivery arrangements and modalities.
- Real co-design processes should be undertaken as part of effective change management. The current system arrangements appear to have moved service design and costing to behind closed doors which is then imposed on providers (and the public) – with unforeseen service gaps, underfunding and associated lack of buy-in.
- General practice providers (and their appointed representatives) should be directly represented at all funding / contracting negotiations to ensure sustainable, equitable funding for primary care services.
- Commerce Act principles must apply (the system should not hide behind Crown exemptions to avoid paying fair rates or to avoid fairly funding inflation or to avoid Providers having a fair negotiation/dispute mechanism).

G. COVID:

New Zealand's response to the COVID pandemic, and more recently the implementation of community isolation for COVID positive patients, has provided important learnings for the reform process and specifically the role of primary care and general practice. GenPro would specifically suggest that:

- The success of managing COVID in the future, and ensuring a highly-performing health system, will come from incorporating:
    - Proactive and prospective engagement with general practice
    - Genuine service co-design as detailed above
    - Clarity of responsibilities and certainty of clinical governance (e.g. The lack of effective transfer of care arrangements for COVID positive patients between regional Public Health Units and general practice has resulted in significant service failures at an individual patient level)
    - The avoidance of high-cost service duplication and fragmentation (e.g. High unit-cost, DHB led COVID vaccination clinics were repeatedly established where general practice was ready and willing to vaccinate their own patients - but were prevented from doing so)
    - The avoidance of high-cost administrative duplication and fragmentation (e.g. Parallel systems were set up for patients vaccine passes – these could have been included within

existing patient portals. The COVID immunisation register (CIR) was set up as a parallel system when the NIR could have been extended/strengthened)

- General practice is best placed to support enrolled patients and manage clinical risk (it's what they do and they do well)
- Fair and transparent fee-setting is required which recognises the full cost of providing services plus an acknowledgement of the alternative cost to the whole health system if it was to become overloaded.

H. Funding:

Successive Health Ministers, as well as the current Director General of Health, have acknowledged that Primary Care is significantly underfunded. The Health and Disability Review did likewise. The health reform programme and its associated structural reform will make no difference to front-line health services or outcomes for the population of New Zealand unless the significant underfunding is corrected.

Additional funding must get directly to the front-line of the health system to:

- Appropriately fund current services and the current workforce (correcting years of underfunding and addressing pay parity issues).
- Appropriately fund new service developments and expected service improvements.
- Appropriately fund non-service expectations (e.g. Additional compliance costs and non-clinical time working with Localities).

Similarly, whilst the overall funding envelope must be corrected, the funding for services must be better targeted based on need. The current capitation formula is approximately twenty years out of date and successive reviews have made widely-accepted recommendations for its improvement – which have yet to be implemented.

Appendix A

Extract from GenPro's 29 July 2021 publication:

Function before form: What does my community need?

A submission to support the development of "Localities"

Introduction

In 2018, the Government announced a wide-ranging review of the Health and Disability system in New Zealand, designed to future-proof our health and disability services.

The Review looked at the overall function of the health and disability system and whether the system is balanced towards wellness, access, equity, and sustainability.

The final report on the findings of the Review (Extract provided at Appendix B) was released on 16 June 2020. The report advised that:

> *"Organising services around smaller populations in localities makes it easier to recognise what really matters to people, to build relationships across professions and organisations, and work with other sectors to address the wider determinants of health. The Review has concluded that there is merit in applying a locality model to Tier 1 services in New Zealand".*

In April 2021, the Government published a White Paper providing an overview of the proposed reform of the health and disability system. The supporting narrative advised that "Over the next few years, primary and community services will be reorganised to serve the communities of New Zealand through 'localities'" and went on to say:

> *"Every locality will have a consistent range of core services, but how these services are delivered will be based on the needs and priorities of local communities.*
>
> *Care will be better coordinated and integrated, with information following patients as they move between providers. They will support more convenient care closer to home, including using technology to support a wider range of digital care options.*
>
> *By reorganising primary and community care into localities, we can improve local health outcomes by giving communities more say in the care that is delivered locally and tailoring care to meet local needs and priorities.*
>
> *In most cases people will still have the same relationship with their health providers in the community. The main difference is that those providers will be better supported to provide connected and integrated care".*

The Transition Unit (established within the Department of Prime Minister and Cabinet to support the reform programme) is now seeking input to help to develop Localities (also being called local wellbeing networks). A process to select prototypes of local wellbeing networks will follow and which are expected to go live in early 2022.

This submission has been prepared on behalf of, and in consultation with GenPro members, to help inform the above process of Locality development. GenPro's intent is through this submission, a set of

principles and criteria are offered which will help ensure that the value of localities are greater than the sum of their parts and specifically that they:

- Increase resources going direct to the front-line
- Improve patient outcomes based on the needs of local communities
- Learn from the lessons of the past

Function before form

The Government's current programme of health reform includes possibly the largest structural re-organisation the health system has seen for many years. The abolition of District Health Boards (DHBs), the potential abolition of Primary Health Organisations (PHOs), the establishment of Health New Zealand (Health NZ) with its network of regional and district infrastructure, and the establishment of the Māori Health Authority. By any measure, this is an ambitious re-organisation with significant levels of inherent risk.

The numbers of organisations, directors and senior managers who will now be looking for some form of 'future-proofing' has the potential to side-track the focus of the reforms. Immediate discussions following the publication of the Government's White Paper included the inevitable, but unhelpful and non-productive, predictions of how DHB teams would transition into the new Health NZ structure as well as how PHOs would transition into new Localities. History tells us that such a focus on form before function is likely to come at a high price.

In June 2021, NZ Doctor magazine published an opinion piece by GenPro Chair, Dr Tim Malloy, entitled *Let's put patients before the deck chairs..* This proposes a patient-stratification methodology to ensure the targeted development of Localities.

Similarly, the basis of this submission and its focus on the principles and criteria for successful Localities is intended to ensure that function comes before form and that the focus is maintained on adding value for patients at the front line.

Learning from the past

We cannot afford to repeat the mistakes of the past.

It has long been the case that the New Zealand Health Strategy has sought to rely upon a strong primary care sector which supports the Government's desire to keep New Zealanders healthy and out of hospital. That was certainly one of the main tenets of the New Zealand Primary Health Care Strategy published in February 2001.

The current reform programme includes many similarities to the Primary Care Health Strategy of 2001. Yet the establishment of PHOs to support the original Strategy failed to deliver the intended benefits of multi-disciplinary working, integrated care, system efficiencies, equity of access and, patient outcomes.

There will be many opinions as to why PHOs did not deliver as expected. GenPro believes the key factors include a lack of empowerment and investment in those extended responsibilities, as well as the perverse constraints of a system which remains biased towards hospital-based care through DHBs own provider arms.

Simply saying that primary care must provide more services, more integration and more choice does not magically make it happen. Evidence points to the importance of effective change management to deliver the intended results and outcomes of such processes. This is particularly the case for organisations which rely heavily on human input and expertise. The development of Localities must therefore be appropriately defined, appropriately funded, supported by an alignment of incentives across the whole system and, underpinned by adequately funded change management.

Clear and robust governance

GenPro believes that successful Localities should:

- Be developed from the bottom-up in partnership with whānau, hapu and iwi
- Be clinically led, patient focused and culturally responsive
- Be based on the principles of equity and transparency, including kāwanatanga, tino rangatirotanga and ōritetanga (protects Māori interests, ensures that Māori have control over their own affairs and, upholds equity of Māori and all New Zealanders)
- Clearly identify responsibility for overarching clinical governance
- Avoid duplication
- Be underpinned by an agreed Code of Conduct (for providers *and* patients)
- Ensure that the Locality value is greater than the sum of its parts
- Establish clear priorities based on a health needs assessment and subsequent stratification of the population
- Be held to account for the delivery of those priorities
- Be based on a high-trust, low-bureaucracy environment
- Support continuing clinical autonomy
- Built upon patient and provider input

Appropriate funding and resources

GenPro believes that successful Localities should:

- Be fully and appropriately funded for all services, at all stages of the patient journey, as well as all administrative functions and all associated time demands
- Be funded to support services to be culturally responsive to the needs of the community
- Be funded and supported to provide a new range of early detection and treatment services for a range of conditions which are supported by a case management approach for patients and whānau
- Be funded in a high trust environment which encourages innovation and wider integration of services
- Be funded separately from their constituent Providers (e.g. Avoiding top slicing)
- Be underpinned by a funding framework which ensures sustainability of services for future years
- Be resourced to ensure clinicians are supported by appropriate non-clinical staff that enable the best use of a limited workforce

Patient focussed

GenPro believes that successful Localities should:

- Be driven by the needs of patients and the community with clearly anticipated outcomes (the commissioning cycle)
- Be connected with the community and responsive to the whānau voice

- Be culturally responsive to the needs of the patient and their whānau
- Protect clinical time to focus on the needs of patients
- Empower patients to take control of their own health and wellness with access to an appropriate range of resources and their health data to do so
- Protect and maintain individual patient-practitioner relationships and patient-provider relationships
- Offer timely access to high quality services at a provider of the patient's choice
- Allow patients to access an appropriately trained professional who is qualified and empowered to make the required clinical decisions based on the patient's needs

Effective team working

GenPro believes that successful Localities should:

- Support multi-disciplinary working and a team approach to primary care services (with clearly defined clinical governance accountabilities)
- Support engagement of (and collaboration between) professionals and practitioners, specifically including currently isolated practitioners who may be working in rural and remote locations
- Promote and support essential workforce development and retention
- Support strong relationships between primary and secondary professionals to encourage a whole of system approach (particularly including urgent care services)
- Utilise the collective skills of local providers to support a range of additional services for their community
- Upskill their local providers to support enhanced services that best meet the needs of the local community
- Support primary health professionals, where appropriate, to provide additional services within their scope of practice
- Be innovative across the full service and provider spectrum
- Support the prompt completion and follow-up of all investigations and diagnostics by the instigating clinician
- Be underpinned by nationally funded, robust, inclusive, integrated and secure IT and information systems
- Facilitate seamless referral processes (with fewer, not more decision points)

Supportive provider relationships

GenPro believes that successful Localities should:

- Support continuity and sustainability of essential service provision
- Enable the effective delivery of nationally consistent and nationally determined essential primary care services (avoiding a 'post-code' lottery of service provision)
- Support innovation and development
- Commission services over and above nationally determined and contracted essential services

Appendix B

Astana Declaration on Primary Health Care (World Health Organisation)

Global Conference on Primary Health Care

From Alma-Ata towards universal health coverage and the Sustainable Development Goals

Astana, Kazakhstan, 25 and 26 October 2018

We, Heads of State and Government, ministers and representatives of States and Governments, participating in the Global Conference on Primary Health Care: From Alma-Ata towards universal health coverage and the Sustainable Development Goals, meeting in Astana on 25 and 26 October 2018, reaffirming the commitments expressed in the ambitious and visionary Declaration of Alma-Ata of 1978 and the 2030 Agenda for Sustainable Development, in pursuit of Health for All, hereby make the following Declaration.

We envision

Governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;

Primary health care and health services that are 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;

Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;

Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

I

We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. Convening on the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, in particular to justice and solidarity, and we underline the importance of health for peace, security and socioeconomic development, and their interdependence.

II

We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and

health-related Sustainable Development Goals. We welcome the convening in 2019 of the United Nations General Assembly high-level meeting on UHC, to which this Declaration will contribute. We will each pursue our paths to achieving UHC so that all people have equitable access to the quality and effective health care they need, ensuring that the use of these services does not expose them to financial hardship.

III

We acknowledge that in spite of remarkable progress over the last 40 years, people in all parts of the world still have unaddressed health needs. Remaining healthy is challenging for many people, particularly the poor and people in vulnerable situations. We find it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist.

We will continue to address the growing burden of noncommunicable diseases, which lead to poor health and premature deaths due to tobacco use, the harmful use of alcohol, unhealthy lifestyles and behaviours, and insufficient physical activity and unhealthy diets. Unless we act immediately, we will continue to lose lives prematurely because of wars, violence, epidemics, natural disasters, the health impacts of climate change and extreme weather events and other environmental factors. We must not lose opportunities to halt disease outbreaks and global health threats such as antimicrobial resistance that spread beyond countries' boundaries.

Promotive, preventive, curative, rehabilitative services and palliative care must be accessible to all. We must save millions of people from poverty, particularly extreme poverty, caused by disproportionate out-of-pocket spending on health. We can no longer underemphasize the crucial importance of health promotion and disease prevention, nor tolerate fragmented, unsafe or poor-quality care. We must address the shortage and uneven distribution of health workers. We must act on the growing costs of health care and medicines and vaccines. We cannot afford waste in health care spending due to inefficiency.

We commit to:

IV

Make bold political choices for health across all sectors

We reaffirm the primary role and responsibility of Governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health. We will promote multisectoral action and UHC, engaging relevant stakeholders and empowering local communities to strengthen PHC. We will address economic, social and environmental determinants of health and aim to reduce risk factors by mainstreaming a Health in All Policies approach. We will involve more stakeholders in the achievement of Health for All, leaving no one behind, while addressing and managing conflicts of interest, promoting transparency and implementing participatory governance. We will strive to avoid or mitigate conflicts that undermine health systems and roll back health gains. We must use coherent and inclusive approaches to expand PHC as a pillar of UHC in emergencies, ensuring the continuum of care and the provision of essential health services in line with humanitarian principles. We will appropriately provide and allocate human and other resources to strengthen PHC. We applaud the leadership and example of Governments who have demonstrated strong support for PHC.

V

Build sustainable primary health care PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions. We will prioritize disease prevention and health promotion and will aim to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care. PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of noncommunicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health2 . PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive. We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. We will benefit from sustainable PHC that enhances health systems' resilience to prevent, detect and respond to infectious diseases and outbreaks.

The success of primary health care will be driven by:

Knowledge and capacity-building. We will apply knowledge, including scientific as well as traditional knowledge, to strengthen PHC, improve health outcomes and ensure access for all people to the right care at the right time and at the most appropriate level of care, respecting their rights, needs, dignity and autonomy. We will continue to research and share knowledge and experience, build capacity and improve the delivery of health services and care.

Human resources for health. We will create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context. We will continue to invest in the education, training, recruitment, development, motivation and retention of the PHC workforce, with an appropriate skill mix. We will strive for the retention and availability of the PHC workforce in rural, remote and less developed areas. We assert that the international migration of health personnel should not undermine countries', particularly developing countries', ability to meet the health needs of their populations.

Technology. We support broadening and extending access to a range of health care services through the use of high-quality, safe, effective and affordable medicines, including, as appropriate, traditional medicines, vaccines, diagnostics and other technologies. We will promote their accessibility and their rational and safe use and the protection of personal data. Through advances in information systems, we will be better able to collect appropriately disaggregated, high-quality data and to improve information continuity, disease surveillance, transparency, accountability and monitoring of health system performance. We will use a variety of technologies to improve access to health care, enrich health service delivery, improve the quality of service and patient safety, and increase the efficiency and coordination of care. Through digital and other technologies, we will enable individuals and communities to identify their health needs, participate in the planning and delivery of services and play an active role in maintaining their own health and well-being.

Financing. We call on all countries to continue to invest in PHC to improve health outcomes. We will address the inefficiencies and inequities that expose people to financial hardship resulting from their use of health services by ensuring better allocation of resources for health, adequate financing of primary health care and appropriate reimbursement systems in order to improve access and achieve better health outcomes. We will work towards the financial sustainability, efficiency and resilience of national health systems, appropriately allocating resources to PHC based on national context. We will leave no one behind, including those in fragile situations and conflict-affected areas, by providing access to quality PHC services across the continuum of care.

VI

Empower individuals and communities.

We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. We will promote health literacy and work to satisfy the expectations of individuals and communities for reliable information about health. We will support people in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care, guided by health professionals. We will protect and promote solidarity, ethics and human rights. We will increase community ownership and contribute to the accountability of the public and private sectors for more people to live healthier lives in enabling and health-conducive environments.

VII

Align stakeholder support to national policies, strategies and plans.

We call on all stakeholders – health professionals, academia, patients, civil society, local and international partners, agencies and funds, the private sector, faith-based organizations and others – to align with national policies, strategies and plans across all sectors, including through people-centred, gender-sensitive approaches, and to take joint actions to build stronger and sustainable PHC towards achieving UHC. Stakeholder support can assist countries to direct sufficient human, technological, financial and information resources to PHC. In implementing this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices while fully respecting national sovereignty and human rights.

- **We will act on this Declaration in solidarity and coordination between Governments, the World Health Organization, the United Nations Children's Fund and all other stakeholders.**
- **All people, countries and organizations are encouraged to support this movement.**
- **Countries will periodically review the implementation of this Declaration, in cooperation with stakeholders.**
- **Together we can and will achieve health and well-being for all, leaving no one behind.**