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PRIMARY CARE IN EMERGING MARKETS: CLOSING THE IMPLEMENTATION GAP BETWEEN POLICY AND PRACTICE

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THE ISSUE

Every emerging market health authority says the same thing: primary care must be strengthened.

The WHO says it. National health strategies say it. Development finance institutions say it. The evidence is unambiguous — strong primary care systems reduce hospitalization rates, lower the burden on tertiary facilities, improve chronic disease management, and deliver better health outcomes at significantly lower cost.

And yet, across Africa, the Middle East, and Southeast Asia, primary care remains chronically underfunded, structurally fragmented, and operationally weak.

The gap between policy and practice is not new. It is not accidental. It has specific, identifiable causes — and until those causes are addressed directly, no amount of policy commitment will close it.

THE EVIDENCE

> *"Health authorities in emerging markets constantly call for the implementation of a preventive approach and the strengthening of primary care but struggle to implement effective measures."*
> *— Speyside Group's 2024-2025 Emerging Markets Healthcare Outlook*

Budget restrictions that don't cover the needed investment in workforce, infrastructure, and care solutions are identified as one of the defining healthcare challenges across emerging markets over the next two years. But budget constraints alone do not explain the persistence of the gap. Countries with adequate health budgets still fail to translate primary care investment into functioning primary care systems.

The deeper problem is structural.

Primary care can be the engine powering advances towards Universal Health Coverage and is central to tackling emerging health threats. But that engine requires more than funding to run. It requires governance frameworks, workforce capability, referral systems, and community trust — none of which are built by policy commitment alone.

THREE REASONS THE GAP PERSISTS

1. Investment flows to visibility, not impact

Hospital construction is visible. Primary care strengthening is not. Governments, donors, and investors consistently fund what can be seen — new facilities, new equipment, new technology — while underinvesting in the operational systems that make primary care work. A community health clinic without standardized protocols, trained staff, and referral pathways is not a functioning primary care facility. It is a building.

2. Workforce deployment without system design

Community health workers and primary care clinicians are trained and deployed — but without the governance structures, supervision systems, and clinical pathways that allow them to function effectively. Training without system design produces workers who know what to do but have no operational framework for doing it consistently. The result: variable quality, high turnover, and community distrust.

3. Siloed policy approaches

The traditional siloed approach to healthcare policy is no longer adequate to address complex issues. Instead, a holistic and multidisciplinary approach that encompasses the interconnectedness of healthcare with other sectors is essential. Primary care does not exist in isolation. It connects to education, nutrition, housing, water, and sanitation. Policies that treat primary care as a standalone health system component consistently underperform against the complexity of the problem they are trying to solve.

STRATEGIC RECOMMENDATIONS

- **For Health System Leaders:** Design primary care investments around operational systems — not just facilities and headcount. Every primary care investment should include explicit funding for clinical governance, workflow design, and continuous quality improvement.
- **For Policymakers:** Move from vertical primary care programs to integrated care models that connect primary, secondary, and tertiary levels. Fragmented programs produce fragmented results.
- **For Investors and Development Partners:** Apply the same implementation scrutiny to primary care investments that you apply to hospital investments. The gap between a funded primary care program and a functioning one is an execution gap — and it requires the same sustained operational support to close.

CONCLUSION

The primary care gap in emerging markets is not a funding problem dressed up as a policy problem. It is an execution problem dressed up as a funding problem.

Until health systems, policymakers, and investors invest as seriously in implementation infrastructure as they do in policy commitment, the gap between what primary care could achieve and what it actually delivers will remain stubbornly wide.

The solution begins with honesty about where the gap actually lives — not in the policy, but in the practice.

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