OPEN ACCESS Freely available online

ISSN: 2573-4598
Journal of Patient Care

Commentary

Primary Health Care Economic Evaluation

Guido van*

Department of Population Health, National Center for Chronic Disease and Health Promotion, Atlanta, USA

DESCRIPTION

With the release of a government white paper called the "Dawson Report" in the 1920s, the term "Primary Health Care" (PHC) first appeared in the United Kingdom. In order to address health inequities and handle the growing complexity of health care delivery, the research predicted that PHC centres will become the standard for delivering community health care services. The Alma-Ata Declaration of 1978, which defined PHC as "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," marked a significant development in the concept of PHC over the ensuing decades. The Global Conference on Primary Health Care, which took place 40 years ago, is now reaffirming the world's commitment to PHC as a crucial method of achieving both the United Nations (UN) Sustainable Development Goals (SDGs) and universal health coverage. The absence of a definition that is acknowledged by everyone has thus far prevented PHC from being implemented internationally. A vision for primary health care in the 21st century, the background paper for the Global Conference on Primary Health Care, seeks to address this problem by defining PHC as a whole-of-society approach to health, based on three linked and synergistic components.

The project's expenses and benefits have been compared using the willingness to pay technique in a cost-benefit analysis. Benefits are evaluated as consumer surplus accruing to the community and take the shape of more basic healthcare being more easily accessible. The decrease in average user expenses and the increase in usage of the project-established points of first contact with primary healthcare result in a gain in consumer surplus.

The significant Net Present Value and Benefit Cost Ratio computed for the entire project area and for the two locations individually support the case for the project's economic viability. The results are strongly in favor of decentralizing primary health care along similar lines in the rest of the nation, even though the evaluation technique used must deal with issues like the valuation of community time, aggregated health care services at all points of first contact, and the partial nature of cost-benefit analysis evaluations.

Despite being widely used in health services research, economic assessment is not frequently used to evaluate implementation strategies. The quantity of studies on implementation techniques that exclusively evaluate their impact on behaviour change and health outcomes contrasts substantially with the number of economic analyses. Divergent perspectives on cost and cost-effectiveness, scarce resources for evaluative research, and a lack of facts for decision-making are some of the more tenable explanations.

Economics may have a different role in evaluating implementation techniques depending on the individual and over time. Some refuse to accept information on cost because they adhere to fundamental ethical principles and moral commitments; others, more realistically, see cost considerations as secondary to or complementing other factors, such as clinical effectiveness. But specific implementation tactics do entail costs, regardless of the variations in opinion and how they affect appraisal and decision-making. Simply ignoring these implications may have unfavorable effects, including inefficiencies and disparities that jeopardize the accessibility and provision of healthcare the same reason why spending on the application of research evidence is first taken into consideration.

In reality, a paradox exists: implementation decisions require economic evaluations that produce high-quality data in order for these decisions to be well-informed; economic evaluations require decisions that use their results in order for these evaluations to be supported. Limitations on research capacity and the availability of appropriate data may appear to be valid reasons for decision-makers not to base implementation decisions on some form of economic evaluation.

Economic evaluation of implementation strategies need not be hampered by the use of methods like cost-consequences analysis, cost-effectiveness/utility analysis, or cost-benefit analysis. While explicitly accounting for the resources spent in planning and

Correspondence to: Guido van, Department of Population Health, National Center for Chronic Disease and Health Promotion, Atlanta, USA, E-mail: van@83471.COM

Received: 29-Jun-2022, Manuscript No. JPC-22-17879; **Editor assigned:** 04-Jul-2022, Pre QC No. JPC-22-17879(PQ); **Reviewed:** 21-Jul-2022, QC No. JPC-22-17879; **Revised:** 26-Jul-2022, Manuscript No. JPC-22-17879(R); **Published:** 04-Aug-2022, DOI: 10.35248/2573-4598.22.8.193.

Citation: van G (2022) Primary Health Care Economic Evaluation. J Pat Care. 8:193.

carrying out implementation strategies as a cost of assuring optimal service delivery, the methodology is comparable to the economic evaluation of the services being implemented. Choosing a method needs balancing its information and computational demands against its potential applications in resource allocation decision-making.

The cost-based weighting mechanism suggested in this study offers a means for quantitatively including vertical equity goals along with efficiency goals in economic approaches to allocating health care resources that is process-based as opposed to outcomes-based. The use of health service delivery features captures the process-based definition of equity based on achieving "equity of access" to health services, which is a common policy approach. As a quantifiable measure, it encourages equity concerns to be considered in a consistent, explicit, and transparent manner.