quality primary and secondary health care provided by the public sector in district settings can reduce the burden on tertiary hospital care by preventing the major causes of hospital admissions.

Third, simply increasing health sector allocations is not enough if services are underused or poorly managed. It is encouraging that the new Government of Pakistan has committed to improving governance. Although this will take time, the government should take steps in the immediate future and strengthen the district health system to increase the accountability of local health-care providers. The watchdog role of media and civil society is especially crucial at this level. Innovative implementation mechanisms such as Social Impact Bonds, adopted by some countries to implement social sector welfare programmes, could also be explored in the short run.

Fourth, the culture of patronage in politics must end. In the past, political interference, an absence of accountability, and failure to pay salaries to staff undermined the delivery of primary health care programmes. At the macro level, the practice of granting development funds to favoured individual ministers to spend in their own constituencies has been a hurdle to secure adequate funds for universal primary health care.

Finally, while Pakistan is a signatory to universal health care and the Declaration of Alma-Ata, it needs to recognise health as a human rights issue at the domestic level by granting it constitutional protection. While the 18th Constitutional Amendment inserted a new article (26A) about the right to basic education, an opportunity was lost for inserting a similar article on the right to basic health. In moving forward to improve health and nutrition in Pakistan, implementation of integrated strategies that promote equitable access to services at primary care level must be the cornerstone of any new policy.

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Putting nursing and midwifery at the heart of the Alma-Ata vision

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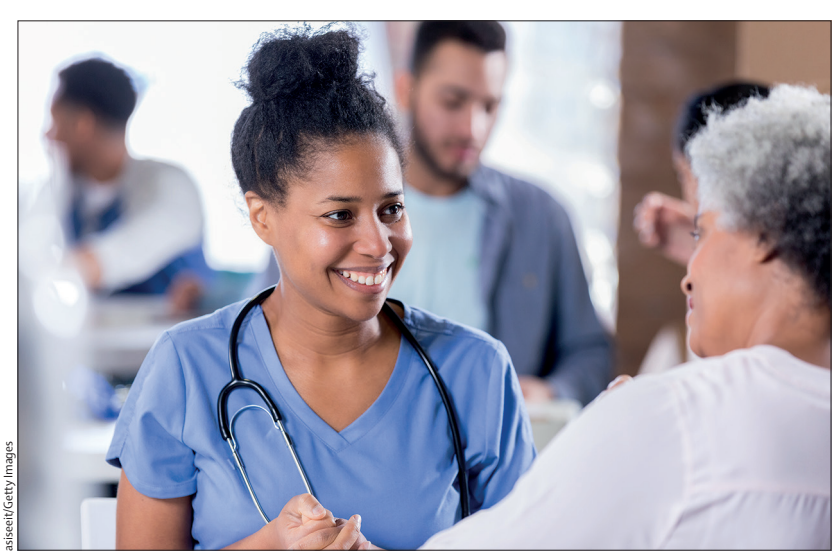
The Alma-Ata vision of a health system rooted in primary health care, which is person-centred and multisectoral, is as relevant now as it ever was. Nursing and midwifery can play a more central part in making this vision a reality. The health workforce has always been central to the 1978 Declaration of Alma-Ata that recognised the important role of health workers in achieving this vision.[1] More recently, the World Health Assembly adopted resolutions on the Global Strategy on Human Resources for Health in 2016[2] and the Working for Health 5-year action plan in 2017[3] that committed countries to develop a primary health care workforce responsive to population needs as part of universal health coverage.

Nurses and midwives are expected to assume a more extensive and influential role in the future.[4] One reason for this changing role arises from epidemiological changes accelerating over the past 40 years. Ageing populations and the increase in non-communicable diseases requires a far more holistic and person-centred approach that fits well with nursing philosophy and practice. Epidemiological change is only one of many changes in every area of life over the past 40 years: in science and technology, politics, economics,

demography, and the environment. All affect health and influence how primary health care can be delivered. We examine three of them here in relation to a nurse-based primary health care system suitable for the future.

First are the great opportunities for improving health that come with today's technology. Examples in primary health care include the Kenyan midwives who use point of care ultrasound in rural areas to identify risk factors in expectant mothers with support from radiologists and the ultrasonography team in a distant teaching hospital.[5] The Apollo Hospitals Group in India has used technology for telemedicine services, which include providing support to clinicians and patients in remote areas. Elsewhere, a young primary care nurse in Australia, Nurse Robbie, has created a suite of tools to support self-care available free to the population and linked to his practice. Meanwhile, in the UK there are now virtual primary care practices. These few examples reveal something of the scale, diversity, geographical spread, and impact that new information and communications technology can have. Together with advances in the biomedical and other sciences, they can bring decision support for clinicians and treatment, information, and advice to patients in their own communities and homes.

Second is the greater understanding and recognition of the wider social determinants of health. The Declaration of Alma-Ata was ahead of its time in recognising the importance of both a cross-sectoral approach and the engagement of communities and citizens. It was not until 30 years later with the 2008 report of the Commission on the Social Determinants of Health that the social determinants of health started to receive wider attention.[6] Policy developments such as health in all policies[7] and asset-based care[8] reflect these ideas, although neither are yet central to policy making in most of the world.



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Alongside these policy developments, there has been growth in many community-based projects, such as the St Paul's Way Transformation Project in London, UK, that bring together actors from all sectors with local residents to improve the area—with improved health as only one of the desired outcomes, alongside educational and economic development. Nursing Now Jamaica has targeted violence against women as one of the biggest issues it must confront in improving health for the country's population. Elsewhere, mothers2mothers in southern Africa has mobilised mothers with HIV to help HIV-positive pregnant women avoid mother-to-child transmission of HIV.

The third development is in human resources. There has been growth in community health workers building on the examples developed by pioneers such as Miriam Were in Kenya at the time of the Declaration of Alma-Ata.[9] Community health workers are being strongly promoted as one of the best ways to bring health care to millions of people living in the most rural areas, as highlighted in the One Million Community Health Workers Campaign.

At the same time, nurses have expanded their practice considerably—eg, prescribing, managing non-communicable diseases, undertaking procedures, being first responders in emergencies.[10] There are now studies that show how effectively nurses can deliver primary care services. A 2018 Cochrane review, for example, concluded that "Delivery of primary healthcare services by nurses instead of doctors probably leads to similar or better patient health and higher patient satisfaction."[11]

In many parts of the world, nurses are the first, and sometimes the only, health professional that patients see. They work close to the community, are able to understand local culture, and influence behaviour. As the 2018 report from the WHO High-Level Commission on Non-Communicable Diseases stated: "nurses have especially crucial roles to play in health promotion and health literacy, and in the prevention and management of NCDs…nurses are uniquely placed to act as effective practitioners, health coaches, spokespersons, and knowledge suppliers for patients and families throughout the life course".[12] It is a statement in the tradition of Alma-Ata.

Medical practice, too, has changed in 40 years with far greater specialisation and a decline in the number of health professionals going into the general specialties. This trend seems set to continue: in the USA between 2001 and 2010, there was a 6·3% decrease in the number of graduate residents entering primary care, but a 45% increase in the medical and surgical subsubspecialties.[13] In Egypt, India, Jordan, Tunisia, and Turkey, less than 10% of physicians choose family medicine.[14]

Taken together these developments suggest a model of primary health care with nurses at its centre, able to call on other medical and specialist support where necessary and refer on to more specialised facilities. In this model, nurses and midwives will provide much of the hands-on care, including the management of non-communicable diseases. They will coordinate, supervise, and support the work of community health workers. Finally, nurses will work with local people and local community groups, such as health coaches and knowledge suppliers, and support self-care, promote health, and prevent diseases.

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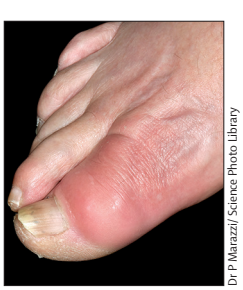
Patient education and engagement in treat-to-target gout care

Gout is the most common inflammatory arthritis worldwide, affecting 4·0% of adults in the USA and 2·5% of adults in the UK.[1] The pathophysiology of this crystal arthritis is well understood, and inexpensive urate-lowering drugs that address the underlying cause of the disease are widely available. Yet gout remains poorly managed, with 70% of patients experiencing recurrent gout flares[2] and substantial burden from tophi and joint damage, which lead to functional limitations and diminished quality of life.

Patients with gout often have concomitant cardiovascular disease, renal insufficiency, and diabetes, making treatment of gout challenging. Compounding this complexity is the time-limited nature of visits with general practitioners (GPs) who provide most gout care in many countries. Moreover, management controversies have arisen due to discordance between recommendations for the management of gout.[3,4] Guidelines from rheumatology organisations universally support a treat-to-target strategy that aims to lower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