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RESEARCH ARTICLE



Strengthening Primary Health Care in Europe: A Delphi study towards accessibility, equity and continuity of care

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KEY MESSAGES

- There is strong consensus on the importance of accessibility, affordability, equity and coordinated care in PHC across Europe, yet participants perceive feasibility to be low and funding insufficient.
- Stronger policy prioritisation is essential to make PHC adequately funded, feasible to implement and sustainable.

ABSTRACT

Introduction: Strengthening Primary Health Care (PHC) is essential for building resilient and equitable health systems, but PHC faces barriers in implementation, resource allocation, and political prioritisation. This study aimed to develop a strategic roadmap to enhance PHC by identifying core values, priorities, and actionable strategies through expert consensus.

Methods: A two-round Delphi study was conducted with 210 stakeholders from 35 countries, including PHC professionals, policymakers, and public health experts. Participants evaluated the importance, feasibility, and policy prioritisation of key PHC values. Quantitative data were analysed using descriptive statistics.

Results: The response rate was 81.4% (171/210) in round one and 73.5% (97/132) in round two. The majority of participants (89%) had a background in medicine. A consensus (>80% agreement) was reached in the first round regarding PHC values. Key recommendations included increasing investment in PHC workforce development, particularly in underserved areas; strengthening health information systems and integrating telehealth solutions; enhancing PHC governance models to support multidisciplinary collaboration and citizen-centred care; and adapting processes to improve chronic care management, end-of-life support, and standardised assessment frameworks. In the second round, when participants assessed the feasibility of these recommendations, agreement levels ranged from 61 to 92%. When asked about the policy prioritisation of these measures, agreement dropped, ranging from 22 to 51%.


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Conclusions: This study highlights that PHC stakeholders perceive a critical need to align health policies with the core values of PHC, while addressing systemic barriers to implementation. Future efforts should focus on bridging the perceived gap between expert recommendations and political prioritisation to achieve sustainable PHC improvements.

Introduction

Primary health care (PHC) serves as the cornerstone of health systems in many European countries, enhancing population health, increasing survival rates and ensuring the equitable use of healthcare resources [1,2]. Globally, the pivotal importance of PHC was first recognised in the Alma-Ata Declaration, which established a framework for family medicine to meet community health needs more effectively [3]. PHC is central to fostering trust between healthcare professionals and patients, optimising resource allocation and delivering comprehensive high-quality care. These contributions improve individual patient outcomes and advance broader societal objectives [4]. Over the decades, high-performing PHC systems have been characterised by their alignment with the ‘sextuple aim’ [1]: providing quality and a positive experience of care [2]; improving population health through universal health coverage (UHC) [3]; ensuring healthcare professionals’ job satisfaction and quality of work [4]; promoting equity and social inclusion [5]; achieving cost efficiency; and [6] fostering environmental sustainability. The COVID-19 pandemic underscored the indispensable role of PHC in managing health crises and protecting public health [5], with the emergence of two additional values: resilience and adaptability. This understanding of PHC is consistent with the WHO definition, which frames PHC as a whole-of-society approach to health that ensures equity and continuity across prevention, treatment, rehabilitation and palliative care [6].

There are significant weaknesses in Europe’s PHC systems, chronic underfunding has left PHC systems with inadequate infrastructure and resources, while workforce shortages, have strained service delivery [6,7]. Fragmentation and poor integration with secondary care, coupled with limited health information system interoperability, hinder coordination and data-driven decision-making. Inequities in access, especially in rural and underserved areas, exacerbate health disparities. The COVID-19 pandemic exposed other vulnerabilities, such as the urgent need for greater investment, workforce expansion, and targeted support for underserved and rural populations [5,8–10]. The climate emergency poses a threat to both human and planetary health, and the 2023 Astana meeting reinforced the importance of implementing the core values of the Alma-Ata Declaration [11].

Although multiple studies have shown that strong PHC systems contribute to improved efficiency and reduced unnecessary hospitalisations and health expenditures [9], the extent to which PHC is considered cost-effective depends on contextual factors such as national health budgets, willingness-to-pay thresholds, and the way PHC is structured and delivered [11,12]. Despite this evidence, PHC remains underprioritised in policymaking, with inconsistent funding and advocacy raising important questions. Why does this evidence fail to translate into concrete political commitments? Are the core values of PHC consistently shared and understood across Europe’s family doctors? Addressing these gaps requires a comprehensive approach to strengthening PHC systems. This study aims to examine these issues by investigating the shared values of PHC among European family doctors and other primary care professionals and their perspectives on the implementation of health policies to strengthen PHC across the continent.

Methods

Study design

The Delphi technique employs a multistage self-administered questionnaire with individual feedback to ascertain consensus from a larger group of experts [13]. We followed the CREDES guidelines, which provide methodological standards for conducting and reporting Delphi studies (Supplement 1 and 2) [14].

Development of the eDelphi survey

A comprehensive literature review was performed to locate all the previous international reports and scientific publications related to the core values and organisational models of PHC. The exploratory review was carried out by the coordinating core group using PubMed, Scopus, and grey literature sources (WHO and OECD reports), with search terms including 'primary health care', 'core values', 'health systems', 'governance', 'equity', and 'resilience'. The Donabedian Healthcare Quality Assessment framework was also considered [15]. A selection of seven core values of PHC within the health system was pre-identified and reformulated based on the perspectives of Starfield, the Astana Declaration, lessons from the COVID-19 pandemic, and community/planetary health: (1) People Centred Care; (2) First Point of Contact and Accessibility; (3) Continuity of care along the years; (4) Comprehensive and coordinated care along care levels; (5) Affordability and Equity; (6) Resilience and Adaptability; (7) Multi-sectoral Partnerships. These values were subsequently presented to the Delphi panel for rating and prioritisation, rather than for initial identification

The research team defined the content of the model. (1) Structure refers to the building structure, health information systems, governance model and funding. (2) processes refer to health promotion and prevention, acute care and out of hours, chronic conditions follow up and caring for an elderly population, end-of-life support, reducing low-value practices, the PHC high-resolution clinical capacity. (3) outcomes refer to assessing procedures and results, data-driven learning and improvement, innovation, better health for all, confidence in the PHC system, and global economic benefit. The model was tested in three online focus groups with European PHC professionals, and it was sent to a list of international PHC experts. After extensive discussions, a questionnaire was built (Figure 1 and Supplement 3). Qualitative data were analysed by two researchers independently to ensure triangulation.

The eDelphi survey rates the statements based on three key dimensions: the relevance of the item (its importance for a PHC system), the feasibility of the item (its practicality for implementation), and its political priority (the perceived need for the item to be a priority in healthcare policies). Consensus was defined as 70% of respondents agreed or strongly agree in the importance of the statement and at least 40% agreed to rate strongly agreed for the item [16]. Non-consensus was defined as less than 70% of respondents agreeing or strongly agreeing. Those statements with less than 70% but more than 50% in consensus ratings were sent to the second round. Those with less than 50% in consensus ratings and without any suggestions for change by the panel after 1st or 2nd round were rejected.

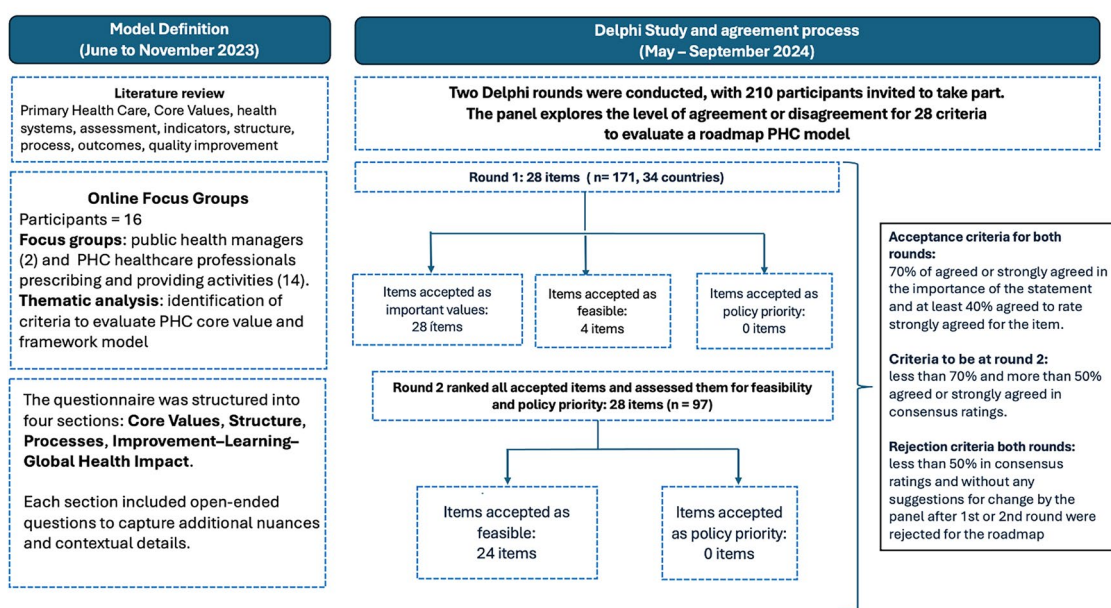


Figure 1. Process steps for constructing the eDelphi survey.

Study setting and expert panel

The panel composition was predominantly family doctors, with limited participation from other professional groups and without patient representatives. A total of 210 panellists were recruited from 35 countries within the Eurasia region, along with one participant from every four countries outside this area (China, Pakistan, the USA, and Venezuela). Selection criteria included [1]: being a PHC professional [2]; membership in either the WONCA Europe organisation or the European General Practitioner Research Network (EGPRN); and [3] being a public health technical officer linked to PHC in a European country participating in the study and nominated by a family doctor associated with both networks. The roadmap was also disseminated in the European Primary Care Forum and in two WONCA Europe meetings of Research [17] and Healthcare quality experts [18].

Data collection and analysis

The online form was built using the Delphi Studies Platform (Qualtrics XM Platform) of Miguel Hernandez University of Elche (Spain). Data collection took place between May and September 2024 each round lasted 2 months and weekly reminders were sent. This online tool allowed for maintaining anonymity among the panellists. For analysing quantitative data, we calculated descriptive statistics of every item using SPSS 27. We used Microsoft Excel to list and categorise qualitative data. Panellists' comments were anonymously and literally registered (Supplement 4). For analysing qualitative data from open-ended survey questions, content analysis was conducted, and two researchers independently ensured triangulation [19].

After the analysis of the first round, the dimension about relevance of the items (its importance for a primary healthcare system) was rated over 80% in all the items. Then, the research team considered not assessing it again in the second round. The second round was sent with only two remaining dimensions to rate: feasibility and political priority.

Results

A total of 210 participants were invited to take part in the study (Table 1). Response rate for round 1 was 81.4% (171/210) and 73.5% (97/132) for round 2. Participants' mean age was 48.1 (standard deviation: 12.0)

Table 1. Characteristics of the invited participants (*n*: 210).

Discipline	<i>n</i>	%
Medicine	187	89.00
Family Medicine	173	89.60
Preventive Medicine and Public Health	9	4.70
Health Care	2	1.00
Cardiology	1	0.50
Clinical pharmacology	1	0.50
General Practice	1	0.50
General surgery	1	0.50
Laboratory Medicine	1	0.50
Medical Science	1	0.50
Not yet specialised	1	0.50
Paediatrics	1	0.50
Public Health	1	0.50
Nursing	7	3.30
Psychology	5	2.40
Law	1	0.50
Administrative work	1	0.50
Pharmacy	1	0.50
Dietetics	1	0.50
Life science	1	0.50
Physical therapy	1	0.50
Clinical Research	1	0.50
Sociology	1	0.50
Information systems	1	0.50
Gerontology	1	0.50
Biomedicine	1	0.50
Working place		
Primary care centre	146	56.20
Primary Care Management	15	5.80
Public Health Institutions	17	6.50
Research units	25	11.90
Policy making	6	2.30
Politics	1	0.40

years, and 61.9% were female. Among participants, 27.1% were from Spain, 8.4% from Italy, and 6.4% from both Croatia and Portugal (Figure 2, Supplement 5). Most participants (89%) had a background in medicine. Over 56.2% worked in PHC, and 28.8% in research units.

An overview of all items evaluated—and whether they were accepted or not in rounds 1 and 2—can be found in Table 2.

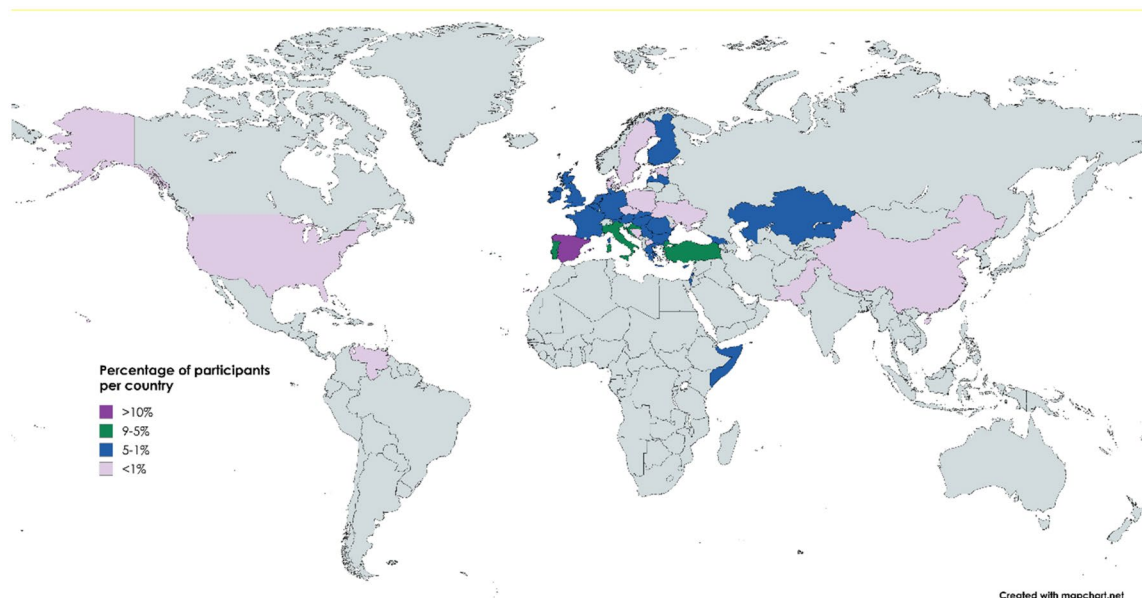


Figure 2. Eurasia map with the participants.

Table 2. Summary of all items evaluated in the Delphi process.

Items assessed in the Delphi study	Accepted in round 1	Accepted in round 2
Section 1: The core values of PHC		
1. Citizens-Centred Care.	Green	Green
2. First point of contact and accessibility.	Green	Green
3. Continuity of care along the years.	Green	Green
4. Comprehensive and teamwork care coordinated along with other healthcare levels.	Green	Green
5. Affordability and Equity.	Green	Green
6. Resilience and Adaptability.	Green	Green
7. Multisectoral Partnerships.	Green	Green
Section 2: Rebuilding PHC structure		
1. Competent PHC Workforce.	Green	Green
2. Safer Buildings. adequate equipment. and a common portfolio of basic service in European PHC.	Green	Green
3. Improve PHC health information systems.	Green	Green
4. Enhance PHC organisation and governance model in the health system.	Green	Green
4.1 Family Doctors are trained in dealing with complex patients with multimorbidity and polypharmacy (more than 5 medications).	Green	Green
4.2 Family Nurses as part of healthcare team are trained in making patients first encounter	Green	Green
4.3 Administrative staff at PHC facilities play an essential role on guaranteeing healthcare quality and patient safety	Green	Green
5. Secure Adequate Funding.	Green	Green
Section 3. Adapting PHC processes		
1. Health promotion and prevention.	Green	Green
2. Acute care and out of hours.	Green	Green
3. Chronic conditions follow up and caring for an elderly population.	Green	Green
3.1 Promotion of follow-up consultations with groups of patients with chronic conditions in PHC facilities	Green	Green
4. End of life support.	Green	Green
5. Reduce low value practices.	Green	Green
6. PHC high resolution clinical capacity. Establish a common PHC service portfolio	Green	Green
Section 4. Global Impact: assessment model to improve, learn, and generate knowledge and innovation		
1. Assessing procedures and results. Developing PHC indicators scorecards	Green	Green
2. Data-Driven Learning and Improvement.	Green	Green
3. Innovation and research in PHC	Green	Green
4. Better health for all. Coordination with public health and other stakeholders	Green	Green
5. Building confidence in PHC system.	Green	Green
6. Global economic benefit.	Green	Green

Legend: PHC (Primary Health Care).

Colours: Items highlighted in green were accepted; items in yellow were rejected. In round 1, items were assessed for importance, feasibility and policy priority. In round 2, items were reassessed for feasibility and policy priority.

The core values of PHC and PHC structure

In the first round, participants strongly agreed on the importance of all PHC core values stated in Section 1, with over 88.6% agreement (Table 3 and 6). The statement identifies PHC as the first point of contact and ensuring accessibility received the highest level of agreement (95.4%) and the highest feasibility rating (75.6%) in round 1. In round 2, the agreement was 83.9%. In round 2, 86% of respondents found the affordability and equity in PHC service delivery statement highly or very highly feasible. Resilience and Adaptability, was not found either feasible or a political priority.

The statement advocating sufficient funding in PHC to address inequalities reached the highest percentage of agreement in both the first round (96.7%) and the second round (86%) (Table 4). However, its feasibility ratings were comparatively lower, with 55.5% in the first round and 49.5% in the second round. The prioritisation of these values in national policies was low across both rounds. In the second round, the highest-rated value maintained PHC as the first point of contact, which received a prioritisation score of 51.6%.

Participants found the statements strongly relevant about adapting PHC processes, achieving over 80.9% of agreement (Table 5 and 6). The feasibility of treating patients with chronic conditions and providing palliative care were the highest-rated values, with a high or very high feasibility agreement of

Table 3. eDelphi Two round scores of items about core values of primary health care.

Section 1: The core values of PHC	First round						Second round			
	Importance		Feasibility		Policy priority		Feasibility		Policy priority	
	Mean	Agree (%)	Mean	Agree (%)	Mean	Agree (%)	Mean	Agree (%)	Mean	Agree (%)
1. Citizens-Centred Care..	4.6	94.1	3.6	58.9	3.0	31.2	4.0	71.0	3.2	36.6
2. First point of contact and accessibility.	4.7	95.4	4.0	75.6	3.2	39.6	4.3	83.9	3.5	51.6
3. Continuity of care along the years.	4.7	94.4	3.7	63.8	2.9	31.6	4.1	77.4	3.0	31.2
4. Comprehensive and teamwork care coordinated along with other healthcare levels.	4.6	94.8	3.8	65.8	3.0	34.2	4.2	81.7	3.1	35.5
5. Affordability and Equity.	4.7	93.8	3.7	59.9	3.1	39.1	4.2	86.0	3.4	49.5
6. Resilience and Adaptability.	4.4	88.6	3.6	53.9	2.6	24.4	4.0	67.7	2.7	19.4
7. Multisectoral Partnerships.	4.5	92.7	3.6	54.9	2.8	27.5	4.1	75.3	3.0	33.3

Legend: PHC: Primary Health Care. Definition of each core value may be found in Supplement 3. Yellow refers to those statements which achieved consensus defined as >70% agreement.

Table 4. eDelphi Two round scores about primary health care structure.

Section 2: Rebuilding PHC structure	First round						Second round			
	Importance		Feasibility		Policy priority		Feasibility		Policy priority	
	Mean	Agree (%)	Mean	Agree (%)	Mean	Agree (%)	Mean	Agree (%)	Mean	Agree (%)
1. Competent PHC Workforce.	4.7	95.2	3.9	66.7	2.7	24.2	4.4	88.2	3.0	32.3
2. Safer Buildings, adequate equipment, and a common portfolio of basic service in European PHC.	4.3	83.1	3.6	58.5	2.7	27.3	3.7	67.7	2.9	34.4
3. Improve PHC health information systems.	4.4	87.0	3.8	67.9	3.1	41.8	4.0	76.1	3.3	42.4
4. Enhance PHC organisation and governance model in the health system.	4.4	89.7	3.6	56.5	2.9	32.6	4.1	77.2	3.0	35.9
4.1 Family Doctors are trained in dealing with complex patients with multimorbidity and polypharmacy (more than 5 medications).	4.7	95.1	4.1	79.7	3.1	38.7	4.5	89.1	3.2	39.1
4.2 Family Nurses as part of healthcare team are trained in making patients first encounter	4.5	91.7	3.8	53.0	2.9	31.9	4.4	86.8	3.2	49.5
4.3 Administrative staff at PHC facilities play an essential role on guaranteeing healthcare quality and patient safety	4.4	85.7	3.7	61.5	2.7	25.3	4.2	84.6	2.8	34.1
5. Secure Adequate Funding.	4.8	96.7	3.6	55.5	2.3	17.6	4.2	85.7	2.6	27.5

Legend: PHC: Primary Health Care. Definition of each subheading may be found in Supplement 3. Yellow refers to those statements which achieved consensus defined as >70% agreement.

Table 5. eDelphi Two round scores about adapting primary health care processes and global impact.

	First round						Second round			
	Importance		Feasibility		Policy priority		Feasibility		Policy priority	
	Mean	Agree (%)	Mean	Agree (%)	Mean	Agree (%)	Mean	Agree (%)	Mean	Agree (%)
Section 3. Adapting PHC processes										
1. Health promotion and prevention.	4.5	89.9	3.8	63.1	2.7	22.3	4.2	79.1	2.8	23.1
2. Acute care and out of hours.	4.2	80.4	3.5	52.0	2.9	34.1	3.9	71.4	3.2	44.0
3. Chronic conditions follow up and caring for an elderly population.	4.7	92.7	4.1	75.8	3.2	44.4	4.5	92.3	3.5	51.6
3.1 Promotion of follow-up consultations with groups of patients with chronic conditions in PHC facilities	4.3	83.7	3.7	60.1	2.7	25.8	4.1	72.5	2.9	30.8
4. End of life support.	4.6	93.8	4	73.0	2.9	35.4	4.3	84.6	3.1	44.0
5. Reduce low value practices.	4.6	91.6	3.7	59.6	2.8	28.7	4.2	81.3	2.9	35.2
6. PHC high resolution clinical capacity. Establish a common PHC service portfolio	4.2	80.9	3.3	46.1	2.5	16.3	3.8	65.9	2.7	19.8
Section 4. Global Impact: assessment model to improve, learn, and generate knowledge and innovation										
1. Assessing procedures and results. Developing PHC indicators scorecards	4.3	85.2	3.7	65.9	3	33.0	4.1	76.9	3.1	38.5
2. Data-Driven Learning and Improvement.	4.5	91.5	3.7	61.9	2.8	27.3	4.2	80.2	3.0	35.2
3. Innovation and research in PHC	4.6	91.5	3.7	59.1	2.4	17.6	4.0	72.5	2.5	25.3
4. Better health for all. Coordination with public health and other stakeholders	4.6	94.9	3.6	52.8	2.6	19.9	4.0	67.0	2.9	26.4
5. Building confidence in PHC system.	4.5	89.8	3.7	59.1	2.4	17.0	4.1	78.0	2.7	28.6
6. Global economic benefit.	4.6	91.5	3.6	56.3	2.4	16.5	4.1	71.4	2.6	22.0

Legend: PHC: Primary Health Care. Definition of each subheading may be found in Supplement 3. Yellow refers to those statements which achieved consensus defined as >70% agreement.

Table 6. Analysis of open-ended items of the eDelphi survey on primary health care.

Question	Main Topics	Example Verbatims	Response Count
P80_1 What are the core values of PHC?	<ul style="list-style-type: none"> - Equity in healthcare delivery - Multidisciplinary collaboration - Accessibility for all 	<ul style="list-style-type: none"> 'Primary healthcare ensures equal access for everyone.' 'Sustainability of health systems is key to achieving these values.' 'Collaboration with nurses, social workers, and other professionals is essential.' 	11
P82_1 How can we operationalise the core values of PHC?	<ul style="list-style-type: none"> - Health system sustainability - Adequate workforce and funding - Involving multidisciplinary teams 	<ul style="list-style-type: none"> 'Aiming at providing administrative support to GPs.' 'The distribution of post-pandemic European funds gave minimal support to primary care compared to other levels.' 'A competent workforce is vital for effective governance.' 	6
P83_1 How can we adapt PHC processes?	<ul style="list-style-type: none"> - Addressing non-communicable diseases (NCDs) - Reducing reliance on emergency care - Tailored care for specific needs 	<ul style="list-style-type: none"> 'Emergency departments have become an alternative access point due to system inefficiencies.' 'We need specialised teams for chronic disease management.' 'Primary care must focus on NCDs to reduce long-term system burdens.' 	6
P84_1 How can we build an assessment model to improve PHC?	<ul style="list-style-type: none"> - Transparent data for improvement - Ensuring continuity of care - Linking funding to outcomes and innovation 	<ul style="list-style-type: none"> 'Continuity with the same GP reduces hospital admissions and improves survival rates.' 'Transparent data is critical for patients and professionals.' 'We need better data to identify gaps and inform investments in primary care.' 	6
P81_1 Do you have any final comments or opinions to add?	<ul style="list-style-type: none"> - Overcoming implementation barriers - Strengthening leadership and teamwork 	<ul style="list-style-type: none"> 'There is a priority in our country related to one of these core values, but in practice, it fails.' 'A robust nutrition service is missing in primary care.' 	5

75.8% and 73%, respectively, in the first round. These values also received relatively high political prioritisation scores in both rounds, with chronic care rated at 44.4% in the first round and 51.6% in the second.

Building an assessment model to improve, learn and generate knowledge and innovation (Table 5 and 6) was considered highly relevant, with agreement levels exceeding 85.2%. The feasibility of these

measures was rated highly in the first round and improved further in the second round. Among these measures, the use of PHC indicators for continuous learning received the highest feasibility score, with 80.2% agreement. However, policy prioritisation for these measures remained low across both rounds.

Discussion

Main findings

We conducted a Delphi study to assess agreement on PHC core values and their integration into PHC structure, processes, and impact among stakeholders in 35 European countries. All statements were deemed highly important (>80% agreement), especially those on accessibility, affordability, equity, and coordinated care. However, feasibility and policy relevance had lower consensus.

Core values of PHC

Round 1 revealed high agreement on the importance of the core values of PHC. The statements about citizen-centred care and PHC as the first point of contact received the highest consensus (94.1% and 95.4%, respectively). The importance of accessibility and affordability was especially emphasised, with over 93% agreeing that PHC must remain affordable and equitable [11]. This consensus supports the global push for universal health coverage (UHC), where PHC serves as the cornerstone for equitable healthcare delivery [20]. However, the feasibility scores were relatively lower, indicating a gap between ideal values and the practicality of implementation. For example, the importance of citizen-centred care and affordability dropped from 94.1% importance to 58.9% feasibility in Round 1. This gap between perceived importance and feasibility echoes findings from various studies that suggest that while the core values of PHC are well-recognised, the operationalisation of these principles often faces significant barriers, including financial constraints, resource allocation, and political will [21].

Rebuilding the PHC structure

Section 2 focused on the organisation and structure of PHC, where the need for sufficient funding, workforce competence, and improved health information systems garnered the highest levels of agreement. The call for adequate funding to address health inequalities was particularly prominent, with over 96% agreement in round 1. This reinforces the argument that financial investment in PHC is crucial for improving service delivery and reducing health disparities [22]. Yet, the feasibility of securing such funding remained a challenge, with feasibility scores hovering around 55% in both rounds. This is consistent with other studies that highlight the persistent underfunding of PHC in many European countries, despite its importance in achieving health system efficiency and UHC [23]. The importance of integrated health information systems also aligns with the growing recognition of digital health solutions, which are essential for modernising and improving the effectiveness of PHC.

Adapting PHC processes

The consensus on the importance of chronic care and palliative care was strong, with 92.7% agreeing on the importance of chronic condition management, and feasibility scores for these areas were high (75.8% and 73%, respectively). These results are consistent with the increasing burden of chronic diseases in ageing populations, necessitating a shift in PHC towards long-term disease management [24]. Furthermore, the findings suggest that while PHC professionals recognise the importance of these areas require more attention in national health policies and practical implementation strategies. The relatively low political prioritisation scores in both rounds indicate that chronic care, though important, is often underfunded or overshadowed by other health system priorities [25].

Another notable result is the disconnect between the high importance ratings of PHC values and their low prioritisation in national policies. While this gap is significant, the underlying reasons—such as geopolitical challenges, socioeconomic disparities, and post-pandemic recovery pressures—were not explicitly investigated.

Strengths and limitations

This study provides valuable insights into strengthening PHC systems across Europe and highlights several notable strengths. The use of the Delphi method enabled consensus-building among a diverse panel of experts, fostering a broad perspective on the core values and structural needs of PHC. The inclusion of stakeholders from 35 countries enhances the generalisability of the findings and offers a comprehensive view of the European PHC landscape. Furthermore, the study's structured methodology and adherence to the CREDES guidelines ensured methodological rigour and reliability. Regarding participation, the Delphi had high response rates for round 1 (81.4%) and round 2 (73.5%) and a gender distribution (67% females) according to the feminisation of the PHC workforce.

This study has several limitations. First, the Delphi panel was predominantly composed of medical professionals, with limited representation from nurses, administrative staff, policymakers, and patient representatives. This imbalance may have narrowed the focus of the study to clinical aspects, overlooking non-clinical dimensions of PHC. Second, the overrepresentation of participants from Spain (27%) reflects the Spanish origins of the Eurodata group, which coordinated and launched the study. Although this facilitated high engagement, it may have introduced a geographic bias. Future research should aim to achieve a more balanced representation across countries and professional groups, including nurses, social workers, policymakers, and patient representatives, in order to capture the full diversity of perspectives relevant to PHC. Finally, as Delphi survey was conducted in English, language barriers may have influenced participation and the depth of qualitative responses for some panellists.

Feasibility ratings varied significantly across countries, reflecting differences in resources, health system maturity, and political commitment. These factors were not deeply explored in this analysis. The Delphi methodology, while effective in achieving consensus, is subject to biases like groupthink and dominance by influential participants. Additionally, the exclusion of patient and caregiver perspectives limits a holistic understanding of PHC needs. The short timeframe (two months per round) may have further constrained deliberation.

Implications for research and practice

The proposed roadmap supports policy development by guiding resource allocation towards accessibility, equity, and governance; provides operational frameworks for integrating telehealth and data-driven systems; emphasises workforce planning through training and incentives; promotes continuous research and adaptation; and enhances health crisis preparedness by improving PHC resilience. Translating these insights into action can bridge the gap between evidence and practice, while investments in infrastructure, workforce, and health information systems, alongside strong political commitment, are essential for sustaining PHC. Future studies should aim for broader stakeholder representation, including the patient's perspective, particularly from underrepresented regions, and consider contextual factors such as economic disparities and political environments.

Conclusion

This Delphi study provides an evidence-based roadmap for strengthening PHC in Europe. While the core principles of PHC are widely recognised, our findings show that stakeholders perceive a gap between these values and their implementation in current health policies. Addressing this perceived misalignment requires overcoming systemic barriers and ensuring sustained political and financial commitment. By doing so, European health systems can move closer to realising the full potential of PHC in promoting accessibility, equity, and resilience.

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Ethical approval

The study was waved by the approval from a Research Ethics Committee for medicinal products, as it does not involve research on or treatment of patients, their samples, or their health data. The wave was obtained from the Ethics Committee of the Hospital Universitario La Paz (Madrid, Spain), 06/2023.

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