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From primary health care to universal health coverage—onestep forward and two steps back

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Primary health care (PHC), codified at the historic 1978 Alma Ata Conference, was advocated as the means to achieve health for all by the year 2000.¹ The principles of PHC included universal access and equitable coverage; comprehensive care emphasising disease prevention and health promotion; community and individual participation in health policy, planning, and provision; intersectoral action on health determinants; and appropriate technology and cost-effective use of available resources.² These principles were to inform health-care provision at all levels of the health system and the programmatic elements of PHC that focused primarily on maternal and child health, communicable diseases, and local social and environmental issues. PHC emphasised community participation through a network of workers at all levels who would be trained both “socially and technically”.¹

Importantly, the Declaration of Alma Ata insisted that

PHC was unlikely to succeed without the establishment of a New International Economic Order (NIEO) based on ensuring the rights of states and peoples under “colonial domination” to restitution and full compensation for their exploitation and that of their resources; regulation of transnational corporations; preferential treatment for low-income and middle-income countries (LMICs) in areas of international economic cooperation; transfer of new technologies; and an end to the waste of natural resources.³ With

the 1980s rise of neoliberal economics, the UN-supported NIEO was abandoned.⁴

In September, 2019, there will be a UN High-Level Meeting on universal health coverage (UHC). UHC is concerned with improved access to quality health services and protection from financial risks associated with health care. However, UHC, unlike PHC, is silent on social determinants of health and community participation. With the global mobilisation behind UHC, the health sector will probably limit its role to Sustainable Development Goal (SDG) 3.8—to achieve UHC. This shift in policy emphasis for the health sector threatens to minimise its role in promoting other health-related SDGs such as food and nutrition (SDG 2), gender equality (SDG 5), and water and sanitation (SDG 6); and, importantly, the reduction of inequality (SDG 10), promotion of environmentally responsible consumption/production patterns (SDG 12), and mitigation of climate change (SDG 4).

Moreover, the term coverage rather than care either suggests a limited scope of care or is being used to suggest enrolment in an insurance scheme. For many LMICs, this has meant operationalising UHC through government-funded health insurance schemes. The adverse implications are seen in countries such as India, where coverage by publicly funded health insurance has neither been equitable nor led to financial protection.⁵ Involving the for-profit private sector in providing health care has allowed for funding imbalances and provider capture, with more funds from these public schemes going into the private health sector, thereby reinforcing existing health inequities.⁶ Insurance-based models of UHC risk being promoted at the expense of funding PHC and other public health programmes.⁷

In 2018, the 40th anniversary of PHC was celebrated at Astana,⁸ where references were repeatedly made to “quality PHC” when it was clear that primary care was meant—ie, care at the first level of contact with the formal health sector. Formulations such as “primary health care is essential to achieving universal health coverage”⁸ portray PHC as a means to attain coverage of health services, whereas equitable access to basic health services has always been a component of PHC. As stated in the widely supported Alternative Civil Society Astana Statement,⁹ it inverts one of the means to achieving PHC whereby UHC becomes the goal. This signals the risk of further medicalisation and commercialisation of healthcare under the UHC model.¹⁰ This year a report of a Pan American Health Organization High-Level Commission raised concern that reform agendas exclusively focused on the health sector, centred on

medical care services and the expansion of insurance coverage, have displaced public health and the social determination of health.¹¹

Although the Declaration of Astana invokes PHC frequently, it gives scant attention to the drivers of ill-health and inequity. There is no hint of the need for a new global economic order for the fullest attainment of health for all, despite the stark social inequalities and greater concentration of wealth than at the time a NIEO was proposed. Indeed, the Declaration of Astana avoids the challenge of what needs to happen from within the health sector to mitigate inequality: intersectoral action at local and policy levels, and strong advocacy from the health constituency for measures to reverse the processes leading to unsustainable inequalities and planetary destruction.¹² Instead, Astana calls for “partnership” with the private sector, notwithstanding the mounting evidence of the commercial determinants of ill-health such as alcohol, tobacco, ultra-processed foods, and industrial and automobile pollution.¹³ Calling for “private sector regulation” by national public authorities to manage conflicts of interest fails to recognise that such authorities, especially in LMICs, are often unable or unwilling to regulate the private sector. The power of transnational corporations, the main vectors of the commercial determinants of health, transcends national boundaries and requires strong and decisive global action both by global civil society and international institutions. In 2018, for example, of the 100 entities with the highest annual revenues, 69 were corporations and 31 were governments.¹⁴

The Declaration of Alma Ata and the movement it inspired was aspirational and ambitious. By reducing PHC to a cornerstone of UHC, as opposed to an umbrella under which UHC resides, the Declaration of Astana confines the health sector to a much more restricted role. With unprecedented threats to population and planetary health, the Declaration of Astana should have been more honest, bolder, and an inspirational guide for those working under increasingly difficult conditions to make health equity a reality. There are concerns that the upcoming UN High-Level Meeting on UHC will compound this policy retreat. Replacing the lodestar of PHC with UHC threatens to be one step forward and two steps back for health policy.

DS and SN are Co-Chairs of the People’s Health Movement Global. SN is State Convener, Public Health

Resource Network Chhattisgarh. CV is Executive Director of the South American Institute of Government in Health. We declare no other competing interests.

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