

The Politics of Primary Health Care **FREE**

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Summary

The global project to achieve Health for All through Primary Health Care (PHC) is a profoundly political one. In seeking to address both universal access to health care and the social determinants of health (SDH) it challenges power blocs which have material vested interests in technical approaches to health and development.

The forces that have shaped PHC include Community Oriented Primary Care and the Health Centre Movement, the “basic health services approach,” and nongovernmental and national initiatives that exemplified comprehensive and participatory approaches to health development. The 1978 Alma-Ata Declaration codified these experiences and advocated Health for All by the year 2000 through PHC. It emphasized equitable and appropriate community and primary-level health care as well as intersectoral actions and community participation to address the social and environmental determinants of health. This would need the support of a new international economic order.

The concept of “Selective Primary Health Care” emerged soon after Alma-Ata, privileging a limited set of technical interventions directed at selected groups, notably young children. This was soon operationalized as UNICEF’s Child Survival Revolution. The visionary and comprehensive policy of PHC was further eroded by the 1970s debt crisis and subsequent economic policies including structural adjustment and accelerated neoliberal globalization that deregulated markets and financial flows and reduced state expenditure on public services. This translated, in many countries, as “health sector reform” with a dominant focus on cost efficiency to the detriment of broad developmental approaches to health. More recently this selective approach has been aggravated by the financing of global health through public-private partnerships that fund specific interventions for selected diseases. They have also spawned many “service delivery” NGOs whose activities have often reinforced a biomedical emphasis, supported by large philanthropic funding such as that of the Gates Foundation.

Educational institutions have largely failed to transform their curricula to incorporate the philosophy and application of PHC to inform the practice of students and graduates, perpetuating weakness in its implementation.

Revitalizing PHC requires at least three key steps: improved equity in access to services, a strong focus on intersectoral action (ISA) to address SDH and prioritization of community-based approaches. The third sustainable development goal (SDGs) focuses on health, with universal health coverage (UHC) at its center. While UHC has the potential to enhance equitable access to comprehensive health care with financial protection, realizing this will require public financing based on social solidarity. Groups with vested interests such as private insurance schemes and corporate service providers have already organized against this approach in some countries. The SDGs also provide an opportunity to enhance ISA, since they include social and environmental goals that could also support the scaling up of Community Health Worker programs and enhanced community participation.

However, SDG-8, which proposes high economic growth based substantially on an extractivist model, contradicts the goals for environmental sustainability. Human-induced environmental degradation, climate change, and global warming have emerged as a major threat to health. As presciently observed at Alma-Ata, the success of PHC, and Health for All requires the establishment of a new, ecologically sustainable, economic order.

Keywords: Alma-Ata Declaration, Health for All, political economy of health, selective primary health care, human resources for health, health-care reform, neoliberal health reform, health equity, health under colonialism, sustainable development goals

Subjects: Global Health, Public Health Policy and Governance

Introduction

The global project to achieve Health for All through PHC has been, since its beginnings, a profoundly political rather than a technical one. This is so because it regards health as a fundamental human right and addresses not only universal access to health care but also the social determinants of health. This approach challenges power blocs that have material vested interests in technical approaches to health and health care.

This chapter reviews the forces that have shaped PHC since the colonial era and then considers its future.

The History and Evolution of Primary Health Care

The origin of PHC lies in the substantial failure of colonial approaches to health and health care to address the health and social needs of the majority of indigenous people, many of whom lived in rural areas.

Colonization, Health, and Health Care

Wherever the European has trod, death seems to pursue the aboriginal. We may look to the wide extent of the Americas, Polynesia, the Cape of Good Hope, and Australia, and we find the same result.

—Charles Darwin, *The Voyage of the Beagle*, 1871

Since precolonial times many indigenous peoples have understood that well-being—health—is dependent on the balance and harmony that exists between individuals, families, communities, land, the spirit world, and the universe. Traditional healers play a role in preserving these harmonious relationships and in many countries still serve as the principal caregivers for large numbers of people, offering alternatives to Western notions of health and medicine with its narrow biomedical focus on disease and treatment (World Health Organization, 2007).

In their quest to exploit the anticipated wealth and labor of their empires the governments of mainly Britain, Portugal, Spain, and Germany (and later Belgium) established administrative structures in the areas they conquered. These were run by officials who had little knowledge of the local terrain or of the indigenous people they were set to rule. The political economy and structural violence (Farmer, 2004) of colonial rule profoundly disrupted people's lives and livelihoods and produced lasting inequalities in health and development that laid the foundations for the structural inequities in many low- and middle-income countries (LMICs). (Tilley, 2016).

Colonization brought infectious diseases from Europe to indigenous people with devastating results. In the 16th century, Spanish conquistadores brought smallpox to central America, leading to the decimation of populations and the destruction of two great civilizations, the Incas and the Aztecs, in the space of a few decades. In the 18th and 19th centuries tuberculosis, measles, mumps, rubella, scarlet fever, pneumonia, pertussis, anthrax, influenza, and typhus were brought into Canada, the Pacific islands, Australia, and New Zealand (Pringle, 2015; Riley, 2010; Diamond, 1999).

Meanwhile, the occupied colonial territories, particularly in the tropics, came to be seen by European colonists as dangerous, disease-prone places with unhealthy climates and inhabited by primitive peoples. Europeans—officials, civil servants, troops, missionaries, and traders—developed exotic diseases and many died. The realization that infectious agents and parasitic protozoa caused most of this disease burden led to disease control measures and hospital-based health systems that were primarily intended “to make the tropics fit for the white man to inhabit” (Farley, 1988) by preserving the health of colonial officials, troops, and developers. Secondary aims were to limit illness among workers and to prevent the spread of epidemics.

In this way, the health systems in many LMICs came to be broadly shaped by British and European models. They were mainly hospital based, curative in orientation, and staffed by Western-trained health professionals. The initial beneficiaries were administrators and the military, followed by local elites and capitalists, and then laborers whose health was essential to the colonial interests. Those who lived away from European settlements and workplaces, whose health was less likely to affect the colonial enterprise, had little access to these health systems, though some received health care from Christian missionaries who generally served remote rural areas away from government services. Their work both promoted evangelism and opened up tropical Africa. Medical missions later began receiving permanent subsidies from the British administration.

Despite enormous advances in scientific biomedicine with the advent of antibiotics, advances in surgery and anesthetics, as well as in preventive and curative technologies, large swathes of the populations of LMICs did not benefit substantially. This situation continued with little change until the 1960s and 1970s, when the WHO began shifting its focus away from vertical approaches to the control and management of specific diseases (e.g., malaria and tuberculosis) toward meeting “basic health needs in developing countries” and the development of “basic health services.”

Community-Oriented Primary Care and the Health Center Movement

In the 1930s and 1940s, four decades before the conference at Alma-Ata codified PHC as a global social goal, the essential ideas that came to underpin it were implemented in rural South Africa in the form of Community Oriented Primary Care (COPC). A group of progressive and pioneering doctors, notably Sidney and Emily Kark, understood the causal influences and roots of disease, developed practical methods of addressing these and documented their experiences. They were inspired by a concern for social justice that emerged from their experience of living in an oppressive multicultural society established by more than three centuries of colonialism; they were also driven by a sense of compassion heightened by World War I and the Great Depression of the 1930s. Another key influence was the pioneering work of Rudolf Virchow, who laid the foundation of public health by drawing attention to the fundamental influence of social and environmental determinants of health (Susser, 1999; Brown & Fee, 2002b).

The rise and fall of COPC in South Africa provides lessons for current attempts to improve global health through the sustainable development goals (SDGs) and universal health coverage (UHC).

The Karks established a highly integrated curative, preventive and promotive health service in Pholela, a rural area impoverished by the migrant labor system. They combined treatment of the sick with household health education by trained community-based health assistants. The health assistants also carried out the first census of the local population. This combination of local epidemiology and community-wide interventions was the basis of community-oriented primary care (Yach & Tollman, 1993; Kark & Cassel, 2002; Susser, 1999).

The Karks understood that health was determined by social, economic, and political processes beyond the control of the health service. They postulated a “Community Syndrome” of malnutrition, mental ill-health, and infectious disease, which was rooted in the migrant labor system then imposed by government policy to obtain labor in the mines. They ensured that health and agricultural workers worked closely together to improve the soil and reduce malnutrition overall. This mitigated the Community Syndrome but could not address the underlying determinant, the migrant labor policy.

In 1942 the South African government appointed the National Health Services Commission (NHSC) with the mandate to make recommendations for a national health service that would ensure “adequate medical, dental, nursing and hospital services to all sections of the people” (Jeeves, 2005). In its report, the commission recommended the creation of a single national health service that would be funded by progressive taxation. The health system would be community based, and in developing it “efforts should be directed not towards the provision of more and more hospital beds, but towards the provision of more and more health centres with periodic examination of all members of the population” (Digby, 2008).

Recognizing the importance of the underlying determinants of health, the NHSC emphasized that reform of the health system on its own could achieve little unless the country addressed the underlying social origins of much of the preventable disease affecting it. This was an early recognition of the social determinants of health (Jeeves, 2005, p. 91).

The NHSC's groundbreaking idea of health centers challenged powerful vested interests, including influential provincial health departments and private doctors. The direct tax used to fund the system was unpopular among the voters, who were then overwhelmingly white. The government capitulated under pressure and failed to bring all publicly funded health services under centralized administrative control, and the health centers were starved of resources from the outset.

When the National Party (NP), with its apartheid manifesto, won the 1948 election, the political environment changed drastically, closing "the window that briefly opened for a more innovative approach" (Jeeves, 1988). With the changing political climate, the medical profession became more hostile to any notion of "social medicine." As intended, the first health centers were established in areas where local authorities were unable to provide personal health services or where people were too poor to pay for private health care. But in the antagonistic climate then prevailing, they remained short-staffed and underfunded. Peripheral centers closed within a few years or were handed over to provincial administrations. Contrary to the original intention of promoting equity, health centers were progressively marginalized, and in the end they were "reduced to being a cheap option for black health care" (Marks, 1997).

Discouraged by hostile government policies, the Karks and several of South Africa's most progressive doctors emigrated. Some, including the Karks, established academic public health units in the United States and Israel (Longlett, Kruse, & Wesley, 2001; Brown & Fee, 2002a).

There were similar developments in India, where the rural health center, staffed by paramedical workers or auxiliaries known as medical assistants or health assistants, was promoted in the 1950s and 1960s by the Bhore Commission. In 1952 the newly independent government of India accepted the commission's proposals, but most were not implemented. However, it spawned the building of many primary health centers across India.

In the aftermath of successful anticolonial struggles in East Africa, the rural health center also featured in Maurice King's book *Medical Care in Developing Countries* in a model termed the "basic health services approach" (King, 1967). Elements of this approach were incorporated into policy documents that influenced the development of the PHC strategy.

Although it improved coverage, the health center approach remained service oriented and medicalized, with little community involvement or emphasis on intersectoral action. During the late 1960s and early 1970s health and development planners became more aware of the social and economic dimensions of poor health and that the funds spent on a single teaching hospital could maintain hundreds of health centers or clinics staffed by auxiliary health workers and could extend basic services to underserved populations (King, 1967).

The Emergence and Formalization of Primary Health Care as Global Policy

By 1973 it was clear that WHO's Malaria Eradication Program, as well as the basic health services approach had failed (Litsios, 2002). John Bryant's seminal book *Health and the Developing World* influenced thinking at this time (Bryant, 1969).

In 1975 the Division for Strengthening of Health Services at the WHO released two influential documents: Djukanovic and Mach (1975) and Newell (1975). The latter presented a selection of case studies from many different countries, ranging from “barefoot doctors” in China to a small community health and development project in a Guatemalan Indian village. It included national examples from Cuba, Tanzania, and Venezuela and from local groups in India, Indonesia, Iran, and Niger. The Christian Medical Commission of the World Council of Churches, representing several Christian denominations with significant missionary presence and influence in LMICs, championed many of these initiatives, publishing their experiences in its journal *Contact* (Voigt, 1984).

The WHO realized that improvements in medical technology were of little use unless the underlying socioeconomic causes of illness were addressed and in the absence of appropriately functioning health-care systems and people’s participation. WHO’s motives in publishing these books were to draw attention to common health and development problems and to present successful solutions to them. It was hoped that this information would encourage innovation. Both WHO publications argued convincingly that new approaches to health were urgently needed and were influential in shaping the PHC approach (PHCA) that was to emerge at the Alma-Ata conference in 1978.

Meanwhile, the 1960s and 1970s heralded far-reaching changes in the global political environment with the emergence of decolonized African nations, the spread of nationalist and socialist movements in the Third World, and new theories of development that emphasized long-term socioeconomic growth rather than short-term technological interventions. These contextual developments also significantly influenced the direction of the WHO. Under its new director general, Dr. Halfdan Mahler, the WHO embarked on a process of radical transformation from its emphasis on the prevention and treatment of disease to the broader strategy of primary health care.

These debates and historic events led to the landmark 1978 International Conference on Primary Health Care in Alma-Ata, the capital city of Kazakhstan, in then the Soviet Union. The conference was organized by a steering committee and five working groups. Considerable disagreement emerged in writing the preconference position papers, particularly around the definition and meaning of PHC: a large part of 1977 was spent on drafting descriptions and definitions. Disagreement developed between those who supported a community-centered approach to PHC and those who advocated a health services-centered vision. Tension between these two fundamentally different positions continued through and beyond Alma-Ata (Litsios, 2002).

These divergent positions are reflected in the somewhat ambiguous text of the final declaration. A number of interpretations of PHC are possible. This is elaborated in the section on PHC in high-income countries.

The primary health-care approach (PHCA) that emerged and was codified in the Declaration of Alma-Ata reflected a break from the “Basic Needs Approach” to development. It advocated a New International Economic Order (NIEO) (Hoadley, 1981). The NIEO was an attempt to realign global power in the wake of decolonization and the need for “developing” countries to achieve the

economic equivalent of political independence (Cox, 1979). It implied a global realignment of structural international power relationships (seen as biased toward the industrial countries), thus threatening the prevailing status quo. Proponents of the countervailing “Basic Needs Approach” posited that the essential changes should take place within rather than between countries (Mathieson, 1980).

WHO and UNICEF advocated PHC as the means to achieve Health for All by the year 2000. PHC focused on community and primary-level health care, outlining a strategy to provide more equitable, appropriate, and effective basic health care and also incorporating actions to address the underlying social, economic, and political causes of poor health (“social determinants”). The principles of the PHCA that were espoused included universal access and equitable coverage; comprehensive care emphasizing disease prevention and health promotion; community and individual participation in health policy, planning and provision; intersectoral action; and appropriate technology and cost-effective use of available resources (Bryant & Richmond, 2008). These principles were to inform health-care provision at all levels of the health system and also shape the eight elements or programs of PHC. It is notable that the “elements” of PHC did not include reference to non-communicable diseases or mental ill-health, which were seen as dominant in the industrialized countries, while their presence in LMICs was only just beginning to be recognized. Their exclusion reinforced a perception that PHC, while purporting to be a global policy for health development, was actually aimed mainly at poor countries.

The authors of the declaration were prescient in warning that opposition to PHC was almost inevitable:

It can be seen that the proper application of primary health care will have far-reaching consequences, not only throughout the health sector but also for other social and economic sectors at community level. Moreover, it will significantly influence community organisation in general. Resistance to such change is only to be expected (World Health Organization, 1978).

Selective Primary Health Care: The Counter-Revolution

Indeed, within a year of Alma-Ata this comprehensive approach to PHC was deemed to be “too ambitious” and not financially or operationally workable. In a period of increasing economic conservatism, marked by structural adjustment in many Southern economies and the emergence of free-market economics, comprehensive PHC began to be supplanted by what became known as “selective PHC” (Walsh & Warren, 1979). Proponents characterized the selective approach as the “leading edge” of PHC, labeling it “an interim strategy” to be followed by a more comprehensive approach at a later stage. This selectivity was two-fold in that it selected young children as an especially vulnerable group and also entailed the adoption of a limited set of selected health interventions in LMICs, notably growth monitoring, oral rehydration therapy (ORT), breastfeeding, and immunization (GOBI). SPHC exemplified by GOBI became the centerpiece of UNICEF’s Child Survival Revolution in 1983 (Grant, 1983a).

While these “child survival” technologies and interventions save many lives, they comprise only a few of the actions necessary to control the diseases they target—notably disregarding the “promotive” actions required to address the social and environmental determinants of the problem. For example, while ORT is effective in preventing diarrheal dehydration, it has no impact on the incidence of diarrhea—which would require a combination of improved personal and food hygiene and more accessible clean water and sanitation. Similarly, growth monitoring can identify malnourished children, but enhanced household food security will be necessary to prevent and respond efficiently to malnutrition, whose mitigation will also require reducing the frequency and the severity of certain infectious diseases.

The following year, in response to concerns that GOBI might be too selective, UNICEF expanded it to “GOBI-FFF,” by adding family planning, food supplements, and female education to the basic package. Although the response to the limited version of GOBI had been enthusiastic, the expanded version made little headway among health ministries and donors (Cueto, 2004; Grant, 1983b). The Task Force on Child Survival and Development, supported by donors such as the US Agency for International Development (USAID), also based its work on implementing a core package of priority interventions.

The result was the energetic initiation of selective child survival interventions, especially immunization and diarrhea case management, often through vertical, centrally organized delivery programs that received generous funding to the detriment of the more comprehensive approaches and other health problems.

Advocates of the selective approach pointed to the impressive increases in immunization cover, declines in young child mortality in many countries and the successful eradication of polio from the Americas (Taylor & Jolly, 1988). While there has been improvement in immunization coverage since the establishment of the Global Alliance for Vaccines and Immunization (GAVI), the target of 90% coverage set out in the Global Vaccine Action Plan had not been reached by 2017, with DTP3 remaining at 85% globally. Measles vaccine coverage remains at 85% for the first dose and only 67% for the second—well below the level required to prevent outbreaks (UNICEF, 2018). Although some countries have made substantial progress in reducing inequalities, disparities in immunization coverage, stratified by sex, wealth, or urban-rural residence persist in many countries—even increasing in some.

Similarly, coverage of oral rehydration therapy remains disappointingly low, especially in sub-Saharan Africa where UNICEF estimates that it covers only 30% of the target group, with a much smaller percentage of poor children being covered. While boys and girls are equally likely to receive ORS to treat diarrhea, children in rural areas are less likely to receive them than are their urban peers (Murray & Newby, 2012).

There are also questions about the sustainability of mass immunization campaigns (Hall & Cutts, 1993), the effectiveness of health-facility-based growth monitoring (Chopra & Sanders, 1997), and whether the promotion of ORT as expensive (and often inaccessible) packets of powder is appropriate without any significant promotion of home fluids or a corresponding emphasis on nutrition, water, and sanitation (Sanders, Doherty, Mason, Coovadia, & Costello, 2013). The

relative neglect of the other elements of PHC and the shift of focus toward technical approaches to disease without an equivalent emphasis on equitable social and economic development, intersectoral collaboration, community participation and establishment of sustainable district-level structures suited the prevailing conservative climate of the 1980s (Rifkin & Walt, 1986). It represented avoidance by governments and donors of the more radical challenges of tackling inequalities and the causes of ill-health.

Substantial support for PHC and significant achievements in respect of some of its program elements occurred in the first two decades after Alma-Ata. However, an unfavorable political and economic climate significantly undermined its full implementation in all but a few countries. The major constraining factors were the general absence of a facilitatory economic and social environment and declining political support for community-based development efforts, as well as significant withdrawal by the state from the provision of public services, including health care (WHO, 1998).

The visionary policy of PHC weakened in the aftermath of the 1970s debt crisis, structural adjustment, stagflation, and the domination of global economic policies by neoliberal dogma. Fiscal austerity, a prominent feature of neoliberalism demands “greater value for money.” This, in the context of a changing labor market, rising unemployment, emerging social and demographic trends, and rapid emergence of new technology with major cost implications for health services has driven a process of “health sector reform” in industrialized countries and LMICs.

Neoliberal Health Sector Reform: Continuities with Selective PHC

By the early 1990s, the commitment to PHC in its original conception had been weakened, especially by the policy intervention advanced by the World Bank supported by the US government that came to be termed “health sector reform.”

Selective PHC has important continuities with “health sector reform.” In its highly influential World Development Report of 1993, the World Bank proposed its version of health sector reform (World Bank, 1993). This policy document had some positive features. It acknowledged that poverty and ill-health are causally linked and that economic improvement and action by sectors other than health are likely to lead to improved health. It also discouraged further investment in specialized tertiary care. It recommended that governments adopt a three-pronged policy approach to health reform: promote an enabling environment for families to improve health, increase government spending in health, and facilitate involvement by the private sector.

The key continuity between health sector reform and selective PHC is through “improving government spending” by “rationalisation” of essential interventions (in the form of a “core package” of services) in a quest for economic efficiency. Cost-effectiveness analysis (CEA) has been used to define priority interventions by computing their likely impact on life years saved and estimating their cost. The cheapest, most effective interventions are then selected and grouped as costed “packages” of care (World Bank, 1993). This approach, it is suggested, enables governments to make rational economic choices and prioritize interventions and services. For

example, hygiene promotion (especially handwashing) has been promoted above improved water supply and sanitation as a more cost-effective means of reducing diarrhea (World Health Organization, 1996):

Cost-effectiveness analyses have shown improved water supply and sanitation to be costly ways of improving people's health . . . encouraging people to wash their hands and making soap available have reduced the incidence of diarrheal disease by 32% to 43%.

(WHO Commission on Macroeconomics and Health, 2002)

However, CEA ignores the many other indirect beneficial effects of improved water and sanitation on health and nutrition that are more difficult to cost. Such benefits include freeing up time spent by women collecting water, enabling them to participate in economic activities, more intensive child care, or supporting improved household food production. New interventions such as deworming and vitamin A supplementation were added to the above-selected technologies for governments to provide.

The Effects of Health Sector Reform on Comprehensive PHC and Equitable Health Systems

Used in this fashion, CEA inevitably narrows the scope of PHC to a set of technical interventions, reminiscent of selective PHC. It pays scant attention to the determinants of ill-health and intersectoral responses, effectively negating the essence of comprehensive PHC (CPHC) (Anand & Hanson, 2004).

Neoliberal health sector reform has come to dominate policy in many LMICs. While there is no universal blueprint, it involves restructuring national health agencies; planning more cost-efficient implementation strategies and monitoring systems; introducing user fees for public health services; introducing managed competition between service providers; and involving the private sector through contracting, regulating, and franchising private providers; and decentralizing management (Cassels, 1995). These reforms, especially cost containment and deregulation, have had an adverse impact on the potential for PHC to be implemented efficiently (Commission on Social Determinants of Health, 2017).

There is increasing evidence that privatization of health care undermines a fundamental principle of PHC, namely the achievement of equity in coverage (Mackintosh & Koivusalo, 2005). Rationing, implemented through limited "packages" of care, leads to multitiered health care with package-based safety nets for the poor; social insurance for employed workers and private insurance for the rich. Health care interventions excluded from essential "packages" are increasingly funded "out-of-pocket" and provided by the private sector, thus commercializing health care. For example, only 9% of health-care transactions studied in Tanzania by the late 1990s were found to be provided free of charge (Mackintosh & Tibandebage, 2002).

Finally, when health care is viewed as a commodity, either because of privatization or because of the use of a narrow form of accounting to assess health service activity, then the functions of community mobilization, intersectoral action, and advocacy are unlikely to be rewarded or encouraged by the broader health system.

PHC in High-Income Countries

The Alma-Ata Declaration contains a critical fault line: it defines PHC ambiguously as both a “level of care” and a broad, community-based “approach” to health. These divergent meanings lead to conflicting perceptions and approaches to health and health care. In industrialized countries where there has been a separation of the components of PHC, the clinical aspects (mainly curative with limited preventive and rehabilitative functions) are the responsibility of general medical practitioners, while the promotive and many of the preventive services devolve to other personnel (e.g., environmental health workers) usually employed by local authorities.

Partly as a response to the medicalization and narrowing of PHC, the Ottawa Charter for Health Promotion elaborated the strategy of “health promotion.” A health promotion movement developed in Canada, Australia, and Europe, leading to encouraging initiatives in schools, hospitals, cities, workplaces, and other settings (Ashton & Seymour, 1988; Baum, 1998). In LMICs, however, health promotion programs have not received the attention they received in industrialized countries (WHO, 2016).

While much clinical care remains with doctors working alone or in group practices, there have been some successful examples of comprehensive primary health care in community health centers in Britain, Australia, and Canada. Typically, community boards have managed these centers and have been successful in advancing community participation beyond mere rhetoric. The centers provided a wide range of services to people (including medical, nutrition, physiotherapy, podiatry, speech therapy); support groups (e.g., stress management, counseling, addressing violent behavior, parenting skills, support groups for chronic conditions such as cancer, asthma, and diabetes); and community development and social action on matters such as household violence and local environmental concerns. Influenced by Jack Geiger’s experience of COPC in South Africa, the health center movement started in a poor African American community in the United States in the late 1960s (Geiger, 2002), spreading to other parts of the country in later decades. However, like in other jurisdictions, it has suffered from the trends toward privatization, the contracting out of public services, and a narrowing focus on the “core business” of treating disease rather than preventing it (Freeman et al., 2016).

For example, in Victoria and South Australia, networks of community health centers with local management boards have been amalgamated and have subsequently found it increasingly challenging to do the innovative primary health-care work they performed in the 1980s. They have struggled to sustain their existence as managerialism in health system reforms have introduced an emphasis on market economics (Baum, 1995).

The Impact of New Funding Arrangements on PHC

In LMICs, health programs have become more and more narrow, especially in those countries that are heavily dependent on donor funding. Most donor funds for health in LMICs up to the early 1990s were provided in two ways: from the World Bank in the form of loans and credits; and ear-marked project and program support to LMICs from bilateral donors. The ascendancy of free-market economics and neoliberalism as the hegemonic policy framework has led to criticism of national governments as being cost inefficient. This, together with economic crises associated with a deregulated economic environment, has translated into “austerity” regimes at the national level, often through the intervention of the international financial institutions. This has resulted in a diminution of government funding for domestic comprehensive and developmental approaches (McKee et al., 2012). Similar criticism of multilateral institutions has resulted in a continuing reduction in annual member state financial allocations to WHO’s budget (People’s Health Movement, 2014a). In response to this—and in keeping with the prevailing neoliberal policy discourse—the newly appointed Director General of WHO, Dr. Gro Harlem Brundtland, encouraged the greater involvement of the private sector in the financing of global health through public-private partnerships (PPPs) in the late 1990s (Richter, 2004).

The past two decades or so have seen a dramatic growth of PPPs as global health partnerships (GHPs) or global health initiatives (GHIs) as a new mechanism for channeling donor funds to LMICs:

GHIs are entities that mount a selective response to specific aspects of the global public health agenda. Some focus on developing, or increasing access to specific health products such as drugs or vaccines (for example, the Global Alliance for Vaccines and Immunisation, GAVI). Others attract, manage and allocate funding for a global response to specific diseases or health interventions (for example the Global Fund to fight AIDS, Tuberculosis, and Malaria, (GFATM) or the Roll back Malaria Global Partnership, RBM).

(WHO, 2008)

The World Bank Multi-Country AIDS Program (MAP) and the US President’s Emergency Plan for AIDS Relief (PEPFAR) are sometimes included as GHIs even though their configuration differs somewhat from other public-private initiatives that comprise the bulk of GHIs.

Most of these entities have enormous budgets, and they have become the major sources of health financing in the poorest countries, especially for HIV, TB, and malaria. While their emergence has resulted in an exponential increase in funding for certain programs (especially HIV/AIDS), they have reinforced the selective approach to PHC through countrywide disease-specific funding mechanisms. Their activities are usually vertically implemented and managed and privilege therapeutic interventions and (in selected cases) personal prevention, with little funding for promotive interventions to address either “upstream” determinants, community mobilization, or rehabilitative care (Sanders et al., 2011). The emphasis of GHIs on therapeutic care and

commodities to treat diseases deflects attention from environmental and social determinants, health promotion and effective prevention activities, and thus from comprehensive PHC (Pronyk et al., 2006, p. 37).

GHIs are also fragmenting and undermining country-led approaches and increasing the opportunity costs for already overstretched ministries of health (Buse, Mays, & Walt, 2005; Digby, 2015; Commission on Social Determinants of Health, 2017). There is little coordination among different GHIs, and they are rarely integrated into the health systems of the recipient countries. This has significant implications for the sustainability of programs if the funding from a particular GHI declines or ends.

An additional phenomenon associated with the influence of GHIs has been the sudden growth of “civil society,” predominantly in the form of “service delivery” NGOs—funded nongovernmental entities contracted to provide services, sometimes in partnership with government but often alone. This phenomenon is especially pronounced in the African countries where HIV/AIDS is most prevalent and where external donor funding has often supported the majority of treatment activities (Kapilashrami & O’Brien, 2012).

While these partnerships have undoubtedly allowed the rapid scale-up of HIV treatment programs, many writers have noted that dependency of NGOs on donors has often weakened accountability to their grass-roots constituencies (Fisher, 1997). Moreover, beneficiaries of funding from both state and GHIs tend to pursue a narrow set of activities (e.g., counseling, testing, treatment adherence and rarely engage in addressing social determinants through intersectoral action or community involvement. Kapilashrami has observed that “they tend to be less critical of the positions taken on program priorities and strategies and serve as intermediaries to facilitate and provide organisation assistance and access to the ‘local’” (Kapilashrami & O’Brien, 2012).

In a case study on the GFATM she notes “the growing professionalisation, with an overwhelming focus on targets and recruitments suggesting a depoliticisation of critical voices.” and a diversion of attention away from advocacy and social mobilization. In short, the complexion of civil society has been significantly changed by the advent of GHIs in the context of neoliberalism with its promotion of public-private partnerships (Kapilashrami & O’Brien, 2012).

Philanthrocapitalism

Since the mid-1990s there has been a rapid growth of philanthropy in health and health care as public and multilateral funding has declined. The largest philanthropy is the Bill and Melinda Gates Foundation (BMGF) whose involvement has grown rapidly. Initially focused on technological innovation and support for biomedical interventions (e.g., vaccines), this foundation has recently shown a greater concern for health systems and PHC (McCoy, Kembhavi, Patel, & Luintel, 2009). Since 2015 it has committed substantial funds to aspects of PHC in India, Ethiopia, and Nigeria, all countries with large, poor populations and a substantial disease burden (World Bank, 2015). The BMGF has recently allocated funding for the establishment of an

International Institute for Primary Health Care in Ethiopia that was launched in 2016. One of the institute's objectives is to strengthen PHC development in Africa through enhancing training and research, basing some of its intended capacity building on Ethiopia's recent positive experience (Assefa, 2016).

The BMGF has become a major donor in the field of global health; it is second to the United States in funding the World Health Organization. Its influence in shaping health policy and programs is therefore substantial. Critics have suggested that its focus hitherto has served to strengthen a technical-medicalized version of PHC and express concerns about the increasing power of privately funded organizations in shaping global (and country) health policies, pointing out that a significant portion of the BMGF's funds is ultimately public money in that tax has been foregone on the profits that support the foundation's work. It is still unclear whether the BMGF's greater involvement in health systems development and in working with governments such as that of Ethiopia will strengthen its orientation to and influence in CPHC.

Human Resources for Health

Human resource development for primary health care is of paramount importance. Sufficient numbers of skilled and well-performing health personnel at all levels and phases of health systems development are a prerequisite for the realization of Health for All. Human resource planning must consider both the numbers, and more importantly, the competencies of personnel required to implement PHC. A key weakness that has undermined its implementation has been the failure of health professional educational institutions to fundamentally transform their curricula to incorporate the philosophy and application of PHC to inform the practice of students and graduates (Frenk et al., 2010).

Critical pedagogy, curriculum content and an appropriate choice of the venues of learning are crucial elements. The aim should be to ensure that learners develop competencies that cover a broader range than tradition dictates. A growing body of evidence indicates that problem-oriented, community, and practice-based approaches result in more relevant learning and in the development of problem-solving skills, allowing health workers to contribute to a health system based on PHC. There is also a compelling need for teaching personnel in the health sciences to upgrade their skills to implement such a reorientation of the curricula. This will require substantial staff development programs. These recommendations for education reform apply to all health professional disciplines and to undergraduate, postgraduate and continuing education and training. Nurses have a central role in the PHC team, and also constitute the largest category of health workers in most countries. Support for such educational reforms and their full elaboration and promotion by countries' nursing institutions and leadership is essential for progress towards Health for All (WHO Expert Group on Nursing and Midwifery Education, 2001).

Continuing education and training is necessary in three (related) areas. Firstly, many health (and health-related) personnel who had their training in the distant past and have worked in the health system for many years will benefit from general courses to orientate them in comprehensive PHC. The second type of educational exposure should focus on comprehensive approaches to specific program-related areas, given the advances that have occurred in

understanding and applying technical and social factors. The third type of training should focus on strengthening management, including of resources (human and material, including pharmaceuticals), finances, and information. Close attention to appropriate settings and vehicles for learning will be productive. Undertaking some of the above in-service learning in multidisciplinary teams is important and valuable in promoting better teamwork (World Health Organization, 2011).

What is Necessary for CPHC to Be Revitalized?

The question of whether CPHC can be revitalized is routinely posed every few years and especially on anniversaries of the Alma-Ata Declaration. In 2008, to mark the 30th anniversary of the Alma-Ata Declaration, meetings were held in all WHO regions, and a special series in *The Lancet* expressed the continuing interest in comprehensive primary health care (*The Lancet*, 2008). This interest was partially a recognition that mainstream health reforms, most being examples of neoliberal policies applied to the health sector (World Bank, 1993) were accompanied by increasing inequities in health outcomes, as well as the weakening and fragmentation of health systems and their commercialization.

A similar appraisal informed the reassertion of PHC as the central strategy to address the health challenges in LMICs (World Health Organization, 2013). Although the *Lancet* series supported the positive impact of Primary Health Care, it also reflected a bias toward selective PHC. A key article (Rohde et al., 2008) reviewed the 30 large countries that have achieved the highest reduction in under-five mortality. Fourteen were said to have progressed to comprehensive primary health care, which accounted for their striking progress.

However, the use of the term “comprehensive PHC” in this and other papers in the anniversary series is misleading. They refer to predominantly facility-based health-care interventions: “We selected immunisation coverage . . . (DPT3) and contraceptive prevalence rate as indicators of selective primary health care implementation, and skilled birth attendance coverage as a marker of the development of a comprehensive primary health care system.” This characterization of CPHC omits some of its essential components, including intersectoral collaboration and community participation (Rohde et al., 2008).

Another article in the series takes a broader view of PHC (Lawn et al., 2008). In this latter article, improving health and the social environments through effective intersectoral action and local community involvement are identified as crucial. Correspondence following its publication support this view (Legge, DeCeukelaire, Baum, McCoy, & Sanders, 2009).

The Importance of Community Participation and Community-Based Workers

“Community participation” is one of the defining principles of PHC. Participation by community members can be facilitated through the work of community health workers (CHWs). The term CHW is generic and covers a wide range of health workers with differing roles and relationships

with the formal health system, with differences in their training, remuneration, scope of practice, and status—and the degree to which they are accountable to and managed by their communities. In the first wave of national CHW programs in the 1980s the use of volunteers to substitute for other workers and become facility-based was reported (Walt, 1990). Most CHWs, especially in Africa and South Asia, remain unsalaried, leading often to high attrition rates undermining program sustainability. The gendered nature of this exploitation in LMICs is well recognized and perceived as threatening to gains in maternal/child health (Langer et al., 2015). Notwithstanding these limitations, volunteer CHWs report positive experiences and personal benefits (such as community respect or benefit from other income-generating opportunities). And sometimes in combination with full-time employed CHWs, these volunteers can contribute to the health and well-being of community members, often with rapid positive impacts on child mortality and morbidity through household level actions (Leon et al., 2015).

Until recently, there has been little robust research to evaluate the role and impact of community involvement in health. In the Lancet Alma-Ata 30th anniversary issue an article that focused on community participation interrogated a crucial policy question: namely, whether specific community participation interventions aimed at women and their families have a direct impact on maternal and child health. After reviewing 13 intervention trials that defined community mobilization as “a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others,” the authors concluded that they resulted in marked improvement in maternal, newborn, and child health (Rosato et al., 2008).

However, beyond these research studies participation by communities in PHC has been the exception rather than the rule. When present, it takes different forms, ranging from provision of voluntary labor such as the construction of latrines in Ethiopia to acting as agents of change to address social determinants in Chhattisgarh State in India. In Chhattisgarh State *mitanin* (local community volunteers) have raised awareness on rights, revitalized local political structures, mobilized women’s collectives, and led social action challenging both the community and government service providers (Nandi & Schneider, 2014).

Structures for community participation in PHC such as health facility or community health committees exist in many countries but seldom operate successfully as sites of true participatory planning and mechanisms to render health services accountable. Their potential to promote democratic participation is facilitated by such contextual factors as leadership, resource provision, supportive health staff and, most of all, a facilitatory external political environment (McCoy, Hall, & Ridge, 2012). In India community-based monitoring of health facilities by village health committee members in Maharashtra State resulted in greater accountability to users (Shukla et al., 2011).

An ambitious initiative launched in 2013 by the Columbia University Earth Institute aims to create “one million community health workers” (One Million Community Health Workers Campaign, 2016). This rapid expansion emphasizes “task-shifting” from professional to lower-level health cadres. This term suggests an instrumentalization of CHWs to mere extenders of services,

detracting from their earlier proposed complementary role as social mobilizers, assisting communities to organize around social determinants of health. This emphasis in the current second wave of CHWs reflects a departure from the earlier vision of comprehensive PHC and tends to reinforce the delivery of selected technical interventions. Although task shifting has already shown potential for rapid improvement of basic health-care coverage, it echoes the seminal paper “The Village Health Worker: Lackey or Liberator?,” which reflected the more radical discourse of PHC in its early period (Werner, 1977).

Outside the health sector there have been other successful examples of community action such as the struggle against water privatization in Bolivia that has had positive effects on social determinants of health, although health outcomes were not specifically quantified (Olivera & Lewis, 2008).

Climate Change, Health, and Health Systems

The medical establishment has become a major threat to health.

—Ivan Illich (Illich, 1976).

Human-induced environmental degradation, climate change, and global warming have profound direct and indirect impacts on health and development, including mass migrations of people and conflict (Kjellstrom & McMichael, 2013; McMichael, 2013). In a 2011 editorial Fiona Godlee, editor of the *British Medical Journal*, says that “the greatest risk to human health is neither communicable nor non-communicable disease, it is climate change” (Godlee, 2011).

The World Health Organization (WHO) estimated that by 2002 global warming due to human-induced climate change was responsible for over 150,000 lives lost annually. This loss of life was a result of extreme weather conditions, water-related diseases such as diarrhea, vector-borne infections including malaria, and increased malnutrition (Patz, Campbell-Lendrum, Holloway, & Foley, 2005). It estimates that the climate change-induced excess risk of the various health outcomes will more than double by the year 2030 (McMichael et al., 2004).

The health risks of climate change can be classified into primary, secondary, and tertiary by causal pathway (McMichael, 2013). Primary risks are due to the direct biologic consequences of heat waves, extreme weather events, and temperature-related levels of urban air pollutants. Secondary risks are brought about by changes in biophysical and ecological systems, particularly food production, water flows, infectious-disease vectors, and intermediate host ecology. Tertiary risks are more diffuse and include mental health impacts, social insecurity, population displacement, conflicts, and war over dwindling resources.

The health consequences of climate change increase will be most felt in the LMICs least prepared to cope with it. Sub-Saharan Africa (SSA), in particular—the region least responsible for climate change—is more vulnerable to its impacts than any other. The most vulnerable people are those who also have the least access to health services: children and women, the poor, the unemployed, those living in crowded homes in peri-urban slums, and those in rural areas.

In the face of such wide-ranging and devastating impacts and vulnerabilities, it is ironic that health systems themselves contribute substantially to climate change through substantial greenhouse gas (GHG) emissions.

Research by the Sustainable Development Unit of the National Health Service (NHS) in England found that, in 2007, the carbon footprint of the NHS was 25.7 million tons of CO₂ equivalent (MtCO₂e) per year (Sustainable Development Unit, 2016). Other high-income countries have similar health sector GHG emissions (Pencheon, Rissel, Hadfield, & Madden, 2009).

It is clear that where data exist, health systems are major contributors to climate change. This renders them fundamentally unsustainable since they are adding to the disease burden they already carry. To be sustainable, health systems must not only meet the health-care needs of all but also address and minimize the growing impacts of climate change by reducing their own GHG emissions. They must also prepare themselves to deal with the inevitable changes in disease patterns that emerge. Furthermore, they must begin to play a leading advocacy role in promoting social justice and equitable socioeconomic development to mitigate the impacts on the poor and vulnerable.

A hospital admission resulted in GHG emissions approximately seven times greater than those of an outpatient visit (Pencheon et al., 2009). Reducing the need for hospital admissions is, therefore, a means of mitigating climate change, and the PHC approach is key to reducing health sector carbon emissions. Quality comprehensive PHC that includes health promotion, disease prevention, low-impact curative care, and rehabilitation—and where activities occur predominantly at lower level facilities (health centers, clinics, and health posts) and at the community level—reduces the burden of disease and minimizes the need to travel to central facilities. Furthermore, advocacy by the health sector for multisectoral action to address the social determinants of health and mobilize communities to participate meaningfully in matters about their health is essential to reduce vulnerability and increase resilience.

The Need to Address Social Determinants Through Intersectoral Action

A recent evaluation of 10 LMICs that achieved their millennium development Goals (MDGs) 4 (reduce under-five mortality by two thirds between 1990 and 2015) and 5 (reduce maternal mortality by three quarters and provide universal coverage of reproductive health services) faster than other comparable countries (i.e., Bangladesh, Cambodia, China, Egypt, Ethiopia, Lao PDR, Nepal, Peru, Rwanda, and Vietnam (hereafter referred to as “fast-track” countries) included statistical and econometric analyses of data from 144 LMICs over 20 years, as well as qualitative comparative analysis, a literature review, and country multi-stakeholder policy reviews. This study found, firstly, that “these countries engage multiple sectors to address crucial health determinants. Around half the reduction in child mortality in LMICs since 1990 is the result of health sector investments, the other half is attributed to investments made in sectors outside health.” The health sector actions included proven high-impact interventions such as skilled care at birth, immunization, and family planning. Secondly, they

use strategies to mobilize partners across society, using timely, robust evidence for decision-making and accountability and a triple planning approach to consider immediate needs, long-term vision and adaptation to change. Third, the countries establish guiding principles that orient progress, align stakeholder action and achieve results over time.

(Kuruvilla et al., 2014)

Notable common intersectoral actions include improving water and sanitation provision, improving education, promoting gender equality, and involving women in policy formulation and program implementation, training, and utilizing community-based health workers in large numbers and regularly monitoring progress and using such data to inform ongoing implementation. Although the contextual factors differed across countries, in all there was evidence of strong “political will” to improve health and social equity on the part of governments.

The Political Context for PHC Implementation

Many evaluations of successful national examples of PHC identify “political will” as an important factor. It often is the case that greatest progress in health improvement—especially for mothers and children—has occurred in countries where policies, structures, and funding are devised and implemented as a result of government clarity and commitment. It is notable, however, that such “political will” is often a feature of authoritarian regimes, whose advent frequently follows a period of political upheaval, sometimes accompanied by popular mobilization for greater social equity. Current examples are Ethiopia and Rwanda, while Iran, Vietnam, Nepal, and China also display some features of centralism and authoritarianism. In Nepal and Vietnam such centralism has to some extent replaced popular political mobilization. While centralism and authoritarianism are in many ways antithetical to the philosophical underpinnings of PHC, they have facilitated the rapid development of local, and especially community-based, governance structures that have been key to the rapid increases in coverage of health interventions and some degree of participation by affected communities in their own health development.

Current Opportunities and Challenges: Universal Health Coverage and the Sustainable Development Goals

In the past decade two major policy initiatives which potentially have far-reaching implications for PHC have come to dominate the health and development discourse. These are universal health coverage (UHC) and the sustainable development goals (SDGs). UHC is now at the center of the health systems discourse and is also invoked as a key target of SDG3, which focuses on health. What are the implications of these for PHC? Can they enhance equity of access to quality health care and address the social determinants of health? What are the opportunities and the challenges?

Universal Health Coverage

According to the WHO, Universal health coverage (UHC) means that all people and communities are able to use the promotive, preventive, curative, rehabilitative, and palliative health services they need (equitable access); that the services are of sufficient quality (effective); and that the use of these services does not expose them to financial hardship (affordable) (WHO, 2018). This is in line with the principles of the Declaration of Alma-Ata (with the welcome addition of palliative care).

There is a broad general consensus on the goals and the benefits of achieving UHC. Moreover, UHC is incorporated as a key target within the 17 wide-ranging and multisectoral SDGs, raising expectations that it may open the road to Health for All. As WHO Director-General Margaret Chan stated in the preface of the WHO's 2015 report on the SDGs:

In health the target on universal health coverage (UHC) provides the platform for integrated action across all 13 health targets. Rather than being seen as one target among many, it is my belief that UHC should be seen as the linchpin of the health development agenda, not only underpinning a more sustainable approach to the achievement of the other health targets, but allowing for a balance between them.

(World Health Organization, 2015)

However, two key questions remain: first, whether UHC can improve equity in access to quality comprehensive health services; and second, whether its incorporation within the SDGs can effectively address the social determinants of health.

Meeting the goals of UHC requires the collection and pooling of revenue to pay for health system benefits. Health systems must ensure equity in health service utilization for the whole population, quality, and financial protection. This, in turn, implies equity and efficiency in the distribution and use of resources, transparency in terms of people's understanding of their rights and obligations, and accountable governance, particularity in relation to the use of public funds. (Kutzin, 2013).

Inevitably, equity implies major redistribution of resources. A recent study of 11 countries attempting to progress toward UHC showed that providing universal coverage for the entire population needs some form of cross-subsidization from the rich to the poor, as well as from low-risk groups (e.g., the young) to high-risk populations (e.g., the elderly) (Reich et al., 2016).

Resource redistribution entails unavoidable political conflicts, negotiations, and compromises. Recently, Gro Harlem Brundtland, Director-General of the World Health Organization from 1998 to 2003 and former prime minister of Norway argued that

UHC can only be achieved by the state compelling healthy and wealthy members of society to subsidise services for the sick and the poor. In effect, UHC can only be reached through public financing where the state has a big role in raising revenues fairly, according to people's ability to pay and allocating pooled resources according to health needs.

Not surprisingly, this transition to a publicly financed health system is often challenged by interest groups that tend to benefit from a fragmented privately financed system—for example private insurance companies, private hospitals, and those who are ideologically opposed to a welfare state. This opposition can be extremely well organised and powerful as we are seeing in the United States and South Africa.

(Brundtland, 2017)

This represents a change of heart by Brundtland. During her tenure as director general she enthusiastically opened up the WHO to private sector involvement.

Joseph Kutzin, Coordinator for Health Financing Policy at the World Health Organization, stresses that regarding health financing for UHC, “The unit of analysis for goals and objectives must be the population and health system as a whole” from the outset. that separate funding arrangements for different population groups, usually beginning with the formal sector workers and civil servants, are a necessary preliminary or transitional stage in moving toward UHC. However, research reveals that

this incremental approach to expansion of health coverage typically leads to the establishment of several risk pools for different population groups with varying amounts of coverage. Once established, these different pools are politically difficult to integrate or harmonise because integration involves redistribution of resources across organised interest groups.

(Reich et al., 2016)

Mandatory prepayment and membership of a national system with funding through tax allows for cross-subsidization of the poor by the wealthy and of the sick by the healthy. But rather than affirming the state's role in providing health services—thereby overcoming market failures in private financing and provision—many powerful proponents of universal health coverage envision a pluralist model in which private insurance schemes and providers (supported by public financing) coexist with public provision in some countries (People's Health Movement, 2014b). Such financing arrangements provide opportunities for private profitmaking in publicly subsidized health systems, usually defended on the basis that the private sector is more efficient and effective in service delivery. However, they contradict the equity principles of PHC, tending to lead to multitiered health-care provision that disproportionately benefits the wealthy, while those who cannot afford membership of such schemes rely on the often-underfunded public sector. This presents a substantial threat to the revitalization of CPHC and undermines progress toward UHC.

PHC in the Era of Globalization

While many LMICs continue to experience undernutrition, communicable diseases, and maternal and child ill-health that affect especially the poor segments of the population, there is simultaneously a rising prevalence of noncommunicable diseases (NCDs) that while initially affecting the better-off strata are increasing among the urban poor. This phenomenon is closely associated with a rapidly changing food and living environment linked to processes of economic globalization. Clearly, this double burden of disease requires for its control an intersectoral and multifaceted approach that includes treatment, rehabilitation, prevention, and promotion. In the current context prevention measures need to respond not only to local factors—as was the focus in the Alma-Ata Declaration—but also to the increasing role of global economic processes in shaping environments. However, even well-designed health systems based on PHC have little control over the broader economic forces that shape the environment. The crucial role of factors outside the health sector was documented in the seminal report of the WHO Commission on Social Determinants of Health published in 2008. It analyzes the links between poverty and health and confirms the importance of addressing the upstream determinants of health that lie outside the ambit of the health sector. Among other factors, it notes: “The combination of binding trade agreements that open domestic markets to global competition and increasing corporate power and capital mobility have arguably diminished individual countries’ capacities to ensure that economic activity contributes to health equity, or at least does not undermine it” (Marmot et al., 2008).

Do the SDGs Address Both Local and Global Social Determinants of Health?

The SDGs, which have replaced the millennium development goals (MDGs), are wide ranging and ambitious. They differ from the MDGs in that they regard the 17 goals as interrelated and indivisible and based on a “whole-of-government” responsibility. There is a focus on equity with an explicit statement that “no-one should be left behind.” A key target of Goal 3, “Good Health and Well-Being,” is to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”

With the inclusion of UHC and stress on the importance of all sectors in achieving sustainable social gains, the SDGs seem to give advocates of the CPHC approach potential opportunities to promote equitable health care for all. But there is also increased opportunity to push for intersectoral action to address the social and environmental determinants of health, including food security and nutrition (SDG2), education (SDG4), gender equality (SDG5), water and sanitation (SDG6), housing, (SDG11) and others. This approach certainly affords an opening for health workers committed to CPHC principles to push for intersectoral action in their own work. This is how the universal health coverage goal within the SDGs was seen in World Health Organization (2015) and is generally given a supporting nod in most statements about universal health coverage.

At the same time, as many commentators have cautioned, there is a risk that the overwhelming ambition of the SDGs will induce sectors to retreat back more firmly into their silos, rather than the reverse. Although initiatives on SDH and Health in All Policies (HiAP) (as the term for Intersectoral Action for Health [IAH] has been rebranded) still define part of the WHO's ongoing work program, there is clearly a comfortable acceptance of the goal of UHC being the health sector's main contribution to the SDGs. There are conflicting views on the SDGs. Critics argue, for example, that the goals are too wide, vague, misconceived, and aspirational: "a betrayal of the world's poorest people" and "worse than useless" (*The Economist*, 2015). Proponents of the SDGs emphasize the genuinely inclusive process that was followed in drafting the goals and point out that the goals are complex because they recognize that poverty is a complex structural problem.

But the key flaws in the SDGs should be seen in the context of climate change and humanity's impact on the earth's ecosystems on which all life depends. Humankind, through its industrialized and growth-dependent economic system, has become a dominant global geophysical force; we have entered the Anthropocene epoch. It began two centuries ago with the industrial revolution, which was made possible through the enormous amounts of energy that could be released by the combustion of fossil fuels (Steffen, Crutzen, & McNeill, 2007; Steffen et al., 2011).

On the surface there seems to be an emerging awareness that the mandatory pursuit of endless industrial growth threatens the basis of our existence. The Open Working Group Proposal for the sustainable development goals, released in August 2014, insists that "planet Earth and its ecosystems are our home" and emphasizes the need to achieve "harmony with nature." It reaffirms the commitments in the UN Framework Convention on Climate Change to cut greenhouse gas emissions to levels that would limit global warming to below 2°C (Körösi & Kamau, 2014).

Yet the SDGs call for sustained and sustainable economic growth while, somewhat unrealistically, endeavoring "to decouple economic growth from environmental degradation" (Goal 8). At the same time, Goals 12 and 13 call for sustainable consumption and production patterns and for urgent action to combat climate change and its impacts (Goals 12 and 13). Other goals include the restoration of water-related ecosystems, a halt to biodiversity loss, and an end to overfishing, deforestation, and desertification.

The core of SDG 1, to end poverty in all its forms everywhere, relies on the old model of industrial growth. Goal 8 calls for at least 7% annual GDP growth in the least-developed countries and higher levels of economic productivity across the board. The emphasis on growth, specifically export-oriented growth, is in keeping with the current neoliberal model. It is based on the assumption that LMICs can model their "development" on the Western industrialized model and become like the countries we refer to as "developed." It implies ever-increasing levels of extraction, production, and consumption and by extension greenhouse gas emissions. This cannot happen without further massive planetary degradation; the Global Footprint Network estimates that if the whole world followed the current development paradigm we would need five to seven planets like Earth (Global Footprint Network, 2017). Taken together, in the context of the global environmental crisis, the MDGs are contradictory to the point of being self-defeating (Hickel, 2015).

A New Ecologically Sustainable Economic Order

The Alma-Ata Declaration emphasized the fundamental importance of the economic and political context to PHC's success, clearly stating that "economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries" (WHO & UNICEF, 1978). The call for a NIEO in the Alma-Ata Declaration reflected the aspirations of the Non-Aligned Movement since the Bandung Conference of 1955 (Ali, 2014), and the first UN Conference on Trade and Development in 1964 (UN Conference on Trade and Development, 1964).

Recent calls for the revitalization of PHC do not mention the NIEO, including those in *The Lancet* anniversary series on Alma-Ata (Lawn et al., 2008).

Yet, the need for a NIEO remains as critical as it was at the time of Alma-Ata. Additionally, the real and present threat to health of the environmental crisis needs to be central to all global economic policies. The significance of an unfair global economic regime in reproducing the health disadvantage of poor people is clearly articulated in the report of the WHO Commission on Social Determinants of Health (Marmot et al., 2008). The UN Department of Economic and Social Affairs has pointed out that since the late 1990s the net flow of financial resources from the developing economies to the industrialized economies dwarfs development assistance flows (UNDSA, 2008).

Record-breaking numbers of refugees and migrants are moving across international borders, fleeing conflict, persecution, poverty, and other life-threatening situations; or they are responding to labor and skill shortages, demographic changes, or seeking better opportunities elsewhere. Their journeys can be fraught with peril; appalling tales of tragedies feature daily in the headlines. Those that make it to a destination are frequently met with hostility. Those host communities trying to provide relief are often unprepared and overburdened by the sheer numbers arriving. Responsibilities are not well distributed: A small number of countries and host communities host disproportionate numbers of refugees, asylum seekers, and migrants. This has impelled populist politics and threatens democracy, which is a fundamental prerequisite for PHC (Buti & Pichelmann, 2017).

Responding to these political crises and reforming the economic forces that are driving this will necessarily require increased regulation of the national and global socioeconomic environment and the powerful entities and structures that are reproducing this situation. The reference to the need for a NIEO in the Alma-Ata Declaration suggests that redressing unfair economic relationships is a necessary condition for the success of PHC. And the radical notion agreed to by the member states of WHO in 1978 was that health development through "community participation" necessarily involves action on the broader environmental and social determinants, and that PHC can catalyze such action. However, the revitalization of PHC as originally envisaged is unlikely without concerted advocacy by supra-national institutions, including the WHO, for a

radically changed, more equitable global economic dispensation that also urgently addresses climate change. Such advocacy is unlikely to occur without a strong global movement for health and social equity.

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