From primary health care to universal coverage – the “affordable dream”
Three decades after the 1978 Health for All declaration, WHO called for a renewed focus on primary health care with the launch of the 2008 World Health Report. When countries sought guidance on financing health care, WHO commissioned a 2010 report on universal health coverage, a concept then pioneered as central to the Sustainable Development Goals and the ambition to leave no one behind.

The 1978 Declaration of Alma-Ata set out primary health care as the way to achieve health for all by the year 2000. It launched a revolutionary movement that did great good but eventually faltered, partly because it was so profoundly misunderstood. It was a radical attack on the medical establishment. It was a standoff between proponents of basic versus specialized care. It was hopelessly utopian; a selective approach, based on just a few inexpensive interventions that brought rapid results, had a better chance of success.

With its reliance on community health workers, it looked cheap: third-rate care for the Third World. For some countries, a declaration associated with a Soviet city raised suspicions that the call was a veiled attempt to push governments towards socialized medicine.

By the mid-1990s, a WHO review of changes in the development landscape bleakly concluded that the goal of health for all by 2000 would not be met. The emergence of HIV/AIDS, the related resurgence of tuberculosis, and an increase in malaria cases moved the focus of international public health away from broad-based programmes and towards the urgent management of high-mortality emergencies.

By the start of the 21st century, when the Millennium Development Goals were put forward as the overarching framework for development cooperation, the epidemics of AIDS, tuberculosis, and malaria were raging out of control. The yearly number of preventable maternal and childhood deaths had been stuck above 10 million for decades. Emergency action was needed.

The global health initiatives that were established to pursue the health-related goals eventually had a tremendous impact, readily measured in the number of interventions delivered, deaths averted and lives prolonged. All of these initiatives depended on well-functioning health systems to deliver medical commodities, yet rarely made the strengthening of health systems an explicit or funded objective. In many cases, weak public health infrastructures were simply

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bypassed through the construction of parallel systems for the procurement and distribution of interventions, for laboratory services, and for budgeting, financing and reporting.

Some warning signals emerge

By 2005, some rumblings of discontent could be heard. Stalled progress towards the health-related MDGs forced a hard look at the results of decades of failure to invest in fundamental health infrastructures, services and staff. In the long term, powerful interventions and the money to purchase them could not buy better health outcomes in the absence of efficient systems for delivery.

The response to the AIDS epidemic, regarded as the most devastating of the three emergencies, was drawing staff away from broad government-funded health programmes, undermining their ability to provide essential services, including preventive care. With systems of financial protection in disarray, out-of-pocket payments for essential care were driving around 100 million people below the poverty line each year – a bitter irony at a time when the alleviation of poverty was the overarching MDG objective.

Opportunities for operational efficiency were being missed. Overlapping diseases were managed by separate initiatives. Single diseases were often managed by multiple initiatives, sometimes using different technical strategies. Duplication of efforts and fragmentation of services were frequent complaints. Some countries felt that their own national health priorities had been crowded out. Who actually owned these initiatives?

The burden on affected countries was heavy. Transaction costs were high. To satisfy donor requirements, some countries were required to issue yearly reports on as many as 600 health indicators. The need to make aid more effective became an urgent issue formally addressed in a series of high-level meetings and calls for major reforms.

Proposed changes took exclusive blame for ineffective aid away from recipient countries and made donor policies and practices equally responsible. Reforms called for greater harmonization of efforts, accountability for results, and alignment with national priorities, systems, and procedures in ways that helped build capacity. Recipient countries made it clear: they wanted capacity, not charity. Strengthened national capacity was the best exit strategy for development assistance.

The 2008 World Health Report: back to the basics

Against this background, WHO retrieved its brand name in 2007, when conferences in all six WHO regions unanimously called for a return to the principles and approaches of primary health care as the best way to organize health services. In that same year, the International Health Partnership was established to put the principles of effective aid into practice. The Partnership
encouraged wide support for a single national health strategy, a single monitoring and evaluation framework, and a strong emphasis on mutual partner accountability. It further encouraged the channelling of assistance through existing systems and structures as a way to build capacity.

Significant support for change came in 2008, when the World Health Report on *Primary health care – now more than ever* was published to mark the 30th anniversary of the Alma-Ata declaration. The report critically assessed the way that health care was organized, financed, and delivered in rich and poor countries alike, and found striking inequalities in access to care, health outcomes, and what people had to pay for care.

Data painted a disturbing picture of ailing health systems that had lost their focus on fair access to care, their ability to invest resources wisely, and their capacity to meet the needs and expectations of people. Fair access to care had particular resonance with lessons learned from the AIDS epidemic. With the advent of antiretroviral therapy, an ability to access medicines and services became equivalent to an ability to survive for many millions of people.

*A revitalization of primary health care was put forward as the best – and most affordable – way to get health systems back on track.* When countries at the same level of economic development were compared, those with health care organized around the tenets of primary health care produced a higher level of health for the same investment. In the largest sense, the report was a call to again put health equality on the international political agenda. A move towards universal health coverage was promoted as the core strategy for tackling inequalities.

The 2008 report of the Commission on the Social Determinants of Health increased the momentum for change with another set of arguments. Deeply concerned about the world’s growing inequalities, the Commission found abundant evidence that the true upstream drivers of ill health come from factors in the social environment, like low incomes, little education, limited employment options, and poor living and working conditions.

The message was optimistic: social environments are shaped by policies, which makes them amenable to change. In the final analysis, the distribution of health within a population is a matter of fairness in the way economic and social policies are designed. In its traditional concern with prevention, public health had much to gain when the narrow biomedical approach to health was extended to include root causes of ill health that reside in non-health sectors. This was new thinking that viewed health as an outcome of social determinants and not merely the result of biomedical interventions.

Not surprisingly, the Commission championed primary health care as a model for a health system that acts on the underlying social determinants of health. Its emphasis on the need to extend prevention to non-health sectors was well-received at a time of growing alarm about the rise of chronic noncommunicable diseases.
Good timing in a very different world

This time around, the call to reorient health systems around primary health care resonated well with some stark and sharply defined concerns. An approach considered revolutionary three decades earlier had secured firm relevance in a very different world. Progress towards the health-related MDGs had stalled. Many attributed the poor progress, especially for maternal and child health, to weak health systems.

The evidence base was strong. Recommendations in the 2008 World Health Report could draw on 30 years of experience in the implementation of primary health care in a diverse range of countries. Rigorous studies confirmed the value of community participation, especially in contributing to sustained reductions in neonatal and maternal deaths. The contribution of community health workers was better defined, including the interventions they could best deliver and the tasks they could best perform. Moreover, evidence showed that this cadre of workers needed to be trained and paid. Several models for shorter durations of training provided an effective strategy for quickly scaling up the workforce.

Large studies coordinated by WHO demonstrated that increasing access to services would not reduce mortality in the absence of a firm emphasis on the quality of care. WHO and its partners no longer supported the training of traditional birth attendants as a route to better maternal health; research indicated that deaths would not go down until more women had access to skilled birth attendants and emergency obstetric care.

In addition, mounting evidence showed that programmes focused on delivering a single intervention, like vaccines, could be expanded to deliver others, thus operating as a stepping stone for building integrated health services. Research further showed that integration of common management functions, such as essential drugs, transport, supervision, and information, for all programmes could be another early step towards providing integrated and comprehensive care.

Simultaneously, the world economic order was abruptly shaken by the 2008 financial crisis, which proved highly contagious in a world of radically increased interdependence. It was also profoundly unfair: even countries that had taken few risks and managed their economies well were severely affected. As the crisis spread, the world economic outlook seemed to move from prosperity to austerity almost overnight.

That shock added to the crisis in health care, characterized by increasing demand, rising costs, and a return to hospital-based curative care. The austere economic outlook brought back some familiar risks. When money is tight, donors and parliamentarians want quick and measurable results, best delivered by a commodity-driven approach. The strengthening of health systems takes time and is notoriously difficult to measure. In a climate of deepening austerity, could the revived enthusiasm for primary health care be sustained?

A series of research papers published in The Lancet concluded that primary health care offered global health a lifeline and a renewed unity of purpose. It was increasingly viewed as the best way to reduce waste and improve efficiencies in service delivery, get the incentives for quality performance right, contain costs in well-off countries, and implement cost-effective interventions in low-resource settings.
The firm emphasis on fairness and social justice spoke to grave concerns about the world’s growing inequalities, in income levels, opportunities, and health outcomes, as a source of social unrest and a potential security threat. The deep-seated focus on prevention and the long-standing call for multisectoral action attracted renewed interest as the best way to tackle the growing burden of chronic diseases.

In the midst of this positive reception, several proponents reminded health officials that universal health coverage, the foundational principle of primary health care, would be an even more powerful corrective strategy. That strategy took shape in 2010.

Universal health coverage: the ultimate expression of fairness

The 2010 World Health Report, on Health system financing: the path to universal coverage, argued for an even more fundamental reorientation of health systems. The report was commissioned by the WHO Director-General in response to a need, expressed by rich and poor countries alike, for practical guidance on ways to finance health care. The objective was to transform the evidence, gathered from studies in a diversity of settings, into a practical menu of options for raising sufficient resources and removing financial barriers to access, especially for the poor.

It gave policy makers a choice. At a time of rising costs, as populations age, chronic diseases increase, and new and more expensive treatments become available, countries should look first for opportunities to reduce waste and inefficiency instead of looking for ways to cut spending.

The report estimated that from 20% to 40% of all health spending was currently wasted and, in a key achievement, pointed to ten specific areas where better policies and practices could increase the impact of expenditures, sometimes dramatically. The overarching message was one of optimism. All countries, at all stages of development, could take immediate steps to move towards universal coverage. Countries that adopt the right policies can achieve vastly improved service coverage and protection against financial risk for any given level of expenditure.

The optimism was not overstated. If the call to revitalize primary health care was warmly welcomed, the response to the WHO push for universal coverage bordered on the sensational. Medical journals organized special issues devoted to exploring its potential and significance in the broader economic and political context. A commentary in The Lancet described the movement towards universal health coverage as a “great transition” that is “sweeping the globe, changing how health care is financed and how health systems are organized.”

International conferences were held, and summits of health ministers added universal coverage to their agendas. Civil society organizations rallied, offering joint statements of support. Within two years, more than 70 countries, at all level of development, had requested WHO technical support in moving their health systems towards universal coverage. By that time, the 2010 World Health Report had been downloaded nearly 700,000 times.
In 2012, the United Nations General Assembly adopted a resolution that endorsed the goal of universal health coverage and gave it a high place on the development agenda. The resolution was sponsored by more than 90 countries, from every region of the world, and adopted by consensus. In a move described by some as “momentous”, the resolution urged Member States to develop health systems that avoid significant direct payments at the point of care. As stated, mechanisms for pooling risk should be introduced to avoid catastrophic health expenditures that drive households into poverty.

The dimensions of the universal health coverage cube

An approach that makes excellent economic sense

Further support came from leading economists. Jeffrey Sachs argued against the “lazy thinking” that continued to justify user fees as a protection against the overuse of health services. As he noted, for the very poor, no price is affordable. Even nominal user fees can lead to massive exclusion of the poor from life-saving health services. Significant progress against malaria began only after WHO policy called for the massive free distribution of insecticidal nets.

Nobel laureate Amartya Sen explained why universal health coverage was an “affordable dream”, even for very poor countries. As he observed, many poor countries have shown that basic
health care for all can be provided at a remarkably good level at very low cost if society, including its political and intellectual leadership, shows high-level commitment.

Sen soundly refuted the common assumption that a poor country must first grow rich before it is able to meet the costs of health care for all. As he argued, health care is labour intensive everywhere. A poor country with low wages may have less money to spend on health, but it also needs to spend less to provide these labour-intensive services.

Finally, Sen explained how universal health coverage provides greater equality, but also much larger overall health gains since it manages the most easily curable diseases and the prevention of easily avoided illnesses that are otherwise left out when the system relies on out-of-pocket payments.

In September 2015, on the eve of the United Nations General Assembly that would adopt the 2030 Agenda for Sustainable Development, leading economists from 44 countries called on global policy makers to prioritize a pro-poor pathway to universal health coverage as an essential pillar of development. As they noted, “Health systems oriented towards universal health coverage, immensely valuable in their own right, produce an array of benefits: in times of crisis, they mitigate the effect of shocks on communities; in times of calm, they foster more cohesive societies and productive economies.”

**Firmly on the agenda**

The inclusion of a target for universal health coverage in the 2030 Agenda for Sustainable Development articulates the very spirit of the agenda’s transformational ambition: leave no one behind. It is the unifying platform for delivering on all other health targets. It is the ultimate expression of fairness and one of the greatest social equalizers among all policy options. It contributes to social cohesion and stability – assets in every country.

The WHO Director-General’s statement, that “universal health coverage is the single most powerful concept that public health has to offer”, looks increasingly accurate. At a time when policies in so many sectors are actually increasing social inequalities, it is especially gratifying to see health lead the world towards greater fairness in ways that matter to each and every person on this planet.
This report is available on WHO’s website
www.who.int/publications/10-year-review/en/