

## Oxford Research Encyclopedia of Global Public Health

### **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years** FREE

Susan B. Rifkin

Subject: Behavioral Science & Health Education, Global Health, Health Services Administration/Management

Online Publication Date: Oct 2018 DOI: 10.1093/acrefore/9780190632366.013.55

### **Summary and Keywords**

In 1978, cca at an international conference in Kazakhstan, the World Health Organization (WHO) and the United Nations Children’s Fund put forward a policy proposal entitled “Primary Health Care” (PHC). Adopted by all the World Health Organization member states, the proposal catalyzed ideas and experiences by which governments and people began to change their views about how good health was obtained and sustained. The Declaration of Alma-Ata (as it is known, after the city in which the conference was held) committed member states to take action to achieve the WHO definition of health as “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Arguing that good health was not merely the result of biomedical advances, health-services provision, and professional care, the declaration stated that health was a human right, that the inequality of health status among the world’s populations was unacceptable, and that people had a right and duty to become involved in the planning and implementation of their own healthcare. It proposed that this policy be supported through collaboration with other government sectors to ensure that health was recognized as a key to development planning.

## **Health for All and Primary Health Care, 1978–2018: A Historical Perspective on Policies and Programs over 40 Years**

---

Under the banner call “Health for All by the Year 2000,” WHO and the United Nations Children’s Fund set out to turn their vision for improving health into practice. They confronted a number of critical challenges. These included defining PHC and translating PHC into practice, developing frameworks to translate equity into action, experiencing both the potential and the limitations of community participation in helping to achieve the WHO definition of health, and seeking the necessary financing to support the transformation of health systems. These challenges were taken up by global, national, and nongovernmental organization programs in efforts to balance the PHC vision with the realities of health-service delivery. The implementation of these programs had varying degrees of success and failure. In the future, PHC will need to address to critical concerns, the first of which is how to address the pressing health issues of the early 21st century, including climate change, control of noncommunicable diseases, global health emergencies, and the cost and effectiveness of humanitarian aid in the light of increasing violent disturbances and issues around global governance. The second is how PHC will influence policies emerging from the increasing understanding that health interventions should be implemented in the context of complexity rather than as linear, predictable solutions.

Keywords: health policy, Primary Health Care, social determinants of health, social justice, universal health coverage, equity, community participation, community health workers, Brazil, Ethiopia, India

---

## **Introduction: A Brief History of Primary Health Care**

In 1978, at an international conference convened by the World Health Organization (WHO) and UNICEF (United Nations Children’s Fund) in Kazakhstan, the 134 members of the World Health Assembly of World Health Organization ratified the Declaration of Alma-Ata (World Health Organization, 1978). The declaration committed member states to supporting Primary Health Care (PHC) as a policy to achieve the WHO definition of health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2006A). PHC was grounded in the concern for social justice created by the devastation in Europe and rapid decolonization of Asia and Africa following the end of the Second World War. The motivation to support the policy arose out of the belief of most of the national governments of the victorious countries that it was imperative to eradicate pervasive poverty and ensure human rights.

PHC was built on the principles of equity in access to health services and the right of people to participate in decisions about their own healthcare (Lawn et al., 2008). Underpinning these principles was support for preventive and promotive health services, appropriate technology, and intersectoral collaboration (Walt & Vaughn, 1981). It has been argued that PHC began a shift in health paradigms—from a definition of health as limited to biomedical research, the provision of health services by professionals, and

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

institutional care in hospitals and subhealth units such as health centers to a broader focus that included the social determinants of health (Bhatia & Rifkin, 2013). Without question, this was a visionary concept that pushed the conventional understanding of how health improves from the realm of biomedicine into a realm of social, economic, and political investigation and action.

To implement the declaration, WHO declared “Health for All by the Year 2000,” creating a goal for national governments that coincided with other UN efforts to address the global and political situation in the 1970s. These efforts included recognizing that health was an integral part of other national development strategies, addressing peoples’ basic needs, and calling for a “new economic order” that was focused on restructuring the world economy to ensure more participation for the so-called developing countries (United Nations General Assembly, 1979). Guided by two extraordinary leaders, Dr. Halfden Mahler, director-general of WHO, and James Grant, executive director of UNICEF, both active Christians committed to social justice (Cueto, 2004), the two organizations began to pioneer ways of transforming health and healthcare to respond to recognized and relevant social, political, and economic conditions. Collaborating closely with the Christian Medical Commission, which supported the presence of medical missionaries in the “developing world,” and with national governments and nongovernmental organizations (NGOs) WHO crafted the Alma Ata Declaration which social justice was the foundation (Cueto, 2004).

This commitment to change the world order to address the needs of the underprivileged was, however, rapidly challenged by events and by people who resisted such radical change. Health professionals published papers suggesting that PHC was more realistically approached by attacking the diseases in developing countries that were the most prevalent and possible to control. Taking up the issue of peoples’ participation in their own healthcare, several governments had started Community Health Worker (CHW) programs in which local lay people were trained to administer first-line healthcare in their communities. Most of these programs proved to be unsustainable, however, because governments resisted incorporating this cadre as government employees with pay and health benefits. After the 1983 global economic crisis produced by increased petroleum prices, financing new approaches to healthcare became a critical issue for developing countries when they were unable to pay their debts to industrial countries and international banks. The result was an era of structural adjustment during which creditors demanded cuts in each country to social welfare programs—specifically to health and education programs—to ensure they would be paid the money owed them. The global health environment increasingly accepted neoliberalism as the dominant financing structure, a view that was strongly supported by a World Bank report entitled *Investing in Health* (World Bank, 1993). The report recommended restructuring the health sector to focus on the cost-effectiveness of delivery and reducing the role of the state. The bank increased its portfolio of loans to this sector in countries that were willing to take up this approach. The director-general of WHO launched an effort to examine healthcare in the World Bank context, producing *The World Health Report 2000: Health Systems; Improving Performance* (WHO, 2000). By 2000, when the UN Millennium Development

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

Goals (MDG) were established, global health policy could be seen as a shift away from a comprehensive PHC approach that took into account social determinants to a vertical disease-focused agenda that reflected a selective PHC approach (see “Selective Primary Health Care Versus Comprehensive Primary Health Care” in the section “Defining and Translating PHC into Practice”).

The *World Development Report 2000* highlighted poverty alleviation and put the focus back on people and social determinants (World Bank, 2000). A new director-general of WHO, J. W. Lee, established the Commission on the Social Determinants of Health in 2005 to investigate the relationship between good health and social determinants, which produced its findings in 2008. The back cover of the published report stated clearly that “reducing health inequities is for the Commission on Social Determinants of Health (CSDH), an ethical imperative. Social injustice is killing people on a grand scale” (Commission on Social Determinants of Health, 2008). In the same year, on the 30th anniversary of the Alma-Ata declaration, WHO also published *The World Health Report 2008: Primary Health Care; Now More Than Ever* (WHO, 2008), which called for reforms that included (a) universal health coverage to improve health equity, (b) health-service-delivery reforms to make health systems more people centered; (c) leadership reforms to improve the accountability of health authorities; and (d) public policy reforms to promote and protect the health of communities. The report identified these reforms as necessary to achieve the PHC movement’s values of “equity, solidarity and social justice” (p. xvi).

These policy documents reflected the knowledge that had been gained from experiences at many levels of PHC implementation. Global programs pursued ways to significantly reduce maternal and childhood deaths through a community-based PHC approach (Perry et al., 2017). For example, the national governments of Brazil, Ethiopia, and India created PHC policies and programs (Gaitonde, San Sebastian, Muraleedharan, & Hurtig, 2017; HEPCAPS1 Project Team, 2012). National and local NGOs developed innovative programs to create and maintain the PHC principles of comprehensive healthcare based on inclusive approaches to improving health that took account of social, political, and economic contexts (Labonte, Sanders, Packer, & Schaay, 2014)

But concomitant with support for PHC, in 2008, the world faced an economic crisis that resulted in shifts from prosperity to austerity almost overnight. In health, increased demand for services, the rising cost of health provision, and a focus on hospital-based curative care became renewed priorities (WHO, 2017). WHO, the UN organization responsible for the technical guidance of global health issues, increasingly struggled to maintain its leadership in the field this field. Financing became a major issue. Country membership dues provided less than one quarter of the organization’s yearly budget. The remaining money came from extrabudgetary sources, predominantly government and private organizations (WHO, N.D.). These funds were most often tied to specific vertical health programs. Organizations, including the World Bank, the Bill and Melinda Gates Foundation, and the Global Alliance for Vaccines and Immunization (GAVI), whose available funds surpassed those of WHO, exerted increasing influence on global health

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

policy and established targeted goals that were not specifically embedded in the PHC vision of health as a human right. WHO was, in addition, having difficulty providing support for the growing HIV/AIDS epidemic, addressing poor health results from weak national health systems, and reducing the costs of medicine needed to treat diseases (both communicable and noncommunicable) afflicting millions of poor people (WHO, 2017).

In this environment, a more concrete and focused policy was necessary. Universal health coverage (UHC), the subject of WHO's *World Health Report: Health Systems Financing; The Path to Universal Coverage*, provided that focus (WHO, 2010). WHO placed UHC in the context of PHC grounded in human rights and equity. However, it clearly addressed solutions to providing a health service based on quality and access, focusing on the need for coverage and preventing catastrophic health payments. Instead of placing health improvements in terms of a critical component of development strategies, it narrowed the scope from including the social determinants of health to actions in the health sector and in roles for both professional and lay health-service providers. In 2015, universal healthcare became an indicator of achievement of the Sustainable Development Goals (SDG), the policy agenda that replaced the MDGs, specifically, Goal 3 (United Nations Development Programme, N.D.). In 2017, the United Nations General Assembly endorsed a resolution placing UHC on the UN policy agenda (Universal Coverage Day, 2012). In the same year, the newly elected director-general of WHO, Tedros Adhanom Ghebreyesus, stated that universal healthcare would be the cornerstone of future WHO policy, featuring equity and community engagement as key elements (Ghebreyesus, 2017).

## **Challenges to PHC**

The history of PHC is the story of attempts to translate the WHO definition of health into action. Traditionally health has been seen as the absence of disease, and healthcare has been presented as care given by people with specialized knowledge. This view of health started to radically change in the 20th century. Globalization provided avenues for the movement of people, knowledge, and ideas; the internet gave lay people access to information about healthcare; and populist movements provided channels for action groups to demand the care to which they now believed they were entitled, not merely as the result of a decision by the doctor. Medicine has been described as both an art and a science (Panda, 2006). It has also been described, by Rudolph Virchow, as “a social science, and politics is nothing else but medicine on a large scale” (quoted in Friedlander, 2005). Both these views reflect the way PHC developed since 1978. This section discussed three critical challenges of translating PHC rhetoric into reality. The next section will focus on experiences of meeting these challenges and the opportunities to implement policy into programs.

## **Defining and Translating PHC into Practice**

The Alma-Ata declaration defines Primary Health Care as

essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every state of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health systems bring health care as close as possible to where people live and work and constitutes the first element of the continuing health care process.

(World Health Organization, 1978, pp. 3-4)

The definition, however, lacked concrete guidelines on how to implement the policy.

### Selective Primary Health Care Versus Comprehensive Primary Health Care

The declaration's lack of concrete guidelines resulted in an attempt by the recognized authorities in the health field to give some shape and form to the concept of Primary Health Care to lead to a definition for global health policy. The Alma-Ata declaration defined eight elements of PHC (World Health Organization, 1978, pp. 24-25). These were:

- “1. Education concerning prevailing health problems and the methods of identifying, preventing and controlling them.
2. Promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation.
3. Maternal and child health care including family planning.
4. Immunization against major infectious diseases.
5. Prevention and control of locally endemic diseases.
6. Treatment of common diseases and injuries.
7. Promotion of mental health.
8. Provision of essential drugs.”

However, no guidance on how to pursue these elements was provided. In an article in the prestigious *New England Journal of Medicine*, Julia Walsh and Kenneth Warren, who was then the director of health sciences at the Rockefeller Foundation, stated that though the vision and values of PHC were unquestionable, translating policy into practice needed refining (Walsh & Warren, 1979). They put forward the concept of “selective primary health care” (SPHC) focusing on implementing policy for the diseases that had the highest prevalence and morbidity, highest risk of mortality, and greatest possibility of control in terms of the cost and effectiveness of the intervention. Rejecting an interpretation of health as holistic and reflective of social justice and social determinants, SPHC put forward a view of health as dependent on vertical delivery of health services. It challenged the alternative “comprehensive Primary Health Care” (CPHC) approaches to health improvements, which included community participation, intersectoral collaboration, and appropriate technology (Rifkin & Walt, 1986).

While WHO struggled with how to pursue a holistic approach to health, the co-sponsor of the Alma-Ata conference, UNICEF, chose to focus on specific interventions, referenced by the acronym GOBI-FFF (**G**rowth Monitoring, **O**ral Rehydration, **B**reast Feeding, **I**mmunizations, **F**amily Planning, **F**emale Literacy, and **F**ood Technology; United Nations Children's Fund, 2016). The Child Survival Revolution, the umbrella for GOBI, was considered a Selective Primary Health Care (SPHC) approach. It focused on maternal and child health and ignored the health of the wider population, including males and seniors. The debate over SPHC versus CPHC became a consistent theme in translating PHC into practice. Should programs focus on priority diseases (the vertical approach) or on a broader set of conditions and activities (the horizontal approach)? Should programs

## Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years

emphasize epidemiological priorities (the most frequent, serious, readily preventable or treatable conditions) or on health priorities as perceived by the local population?

Table 1 illustrates the differences between SPHC and CPHC

Approach	Selective Primary Health Care (SPHC)	Comprehensive PHC (CPHC)
Values	Effectiveness, efficiency, cost-effectiveness	Equity, community participation, intersectoral collaboration
Concepts	Health as absence of disease	Health as well-being
Orientation and Accountability	Vertical, health depends on vertical management and support	Success depends on links between health and other sectors, community support and capacity building
Time Scope	Short-term, donor and program manager dependent	Long-term, population and public health dependent

The vertical–horizontal tension was often reflected in the way health programs were established, particularly in the low- and middle-income “developing countries.” The tensions could be seen in donor financing to these countries (Cruz-Oliveria, Kurowski, & Mills, 2003). Evidence suggests that donor aid often was earmarked for specific disease programs that would provide clear results in a fairly short time. This approach had drawbacks, however. For example, targeted disease programs, such as mass immunization campaigns, were not only inconsistent in ensuring additional routine follow-ups, such as additional polio immunizations, but they also took human resources from health programs that were not directly related to a specific disease-control program, leaving gaps in other critical areas for health improvements. Evidence that questioned the value of vertical programs became available. Evidence from Mexico, for instance, showed that vertical programs integrated into the health system (the horizontal approach) over a 25-year period showed a reduction of child mortality from 64 per 1000 to 23 per 1000. The approach, which bridged clinic care with home care, also showed drastic reductions in diarrhea mortality rates and the elimination of polio, diphtheria, and measles (Sepulveda et al., 2006)

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

In sub-Saharan Africa, vertical HIV/AIDS programs have integrated preventive programs for breast cancer and cervical cancer. These experiences called for a “diagonal” approach to disease control by integrating such programs into the existing health infrastructure and using people and resources to attack several problems at the same time (Orenstein & Seib, 2016). The call for diagonal approaches received attention in the health literature as an argument to find ways of integrating the CPHC and SPHC approaches (Ooms, Van Damme, Baker, Zeitz, & Schrecker, 2008).

The tension between SPHC and CPHC continues to play a critical role in health planning. Although the vertical and horizontal approaches are often presented as mutually exclusive, in reality, many programs are a combination of both. A description of these approaches and their history and variation can be found in a background study done for the World Bank that discusses history and trade-offs of each (Msuya, 2004). The conflict is another aspect of the challenge of finding ways to implement the PHC concept.

### **Differences Between “Primary Care” and “Primary Health Care”**

The second critical challenge to defining and implementing PHC was to make a distinction between primary care and PHC. As with the debate over CPHC and SPHC, the difference was between a comprehensive view about health and one that focused on, in this case, the delivery of a health service. Defined by Barbara Starfield, a leading authority on primary care in the United States, *primary care* was

the level of a health service system that provides entry into the system for all new needs and problems, provides person focused (not disease oriented) care over time, provides care for all but the very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere or by others.

(Starfield, 1998, p. 9)

The concept originated in a 1920 white paper in the United Kingdom that defined three levels of health services, of which hospitals were the first level, subhealth units were the second level, and the primary care health centers were the lowest level (Dawson, 1920). This structure was disseminated throughout the United Kingdom and replicated in many countries, particularly those that were former English colonies. Starfield noted that primary care was more resonant in industrial countries, where the provision of healthcare was based on technology and hospital-based medicine and there was little experience in community-based healthcare (Starfield, 1998).

These terms were often used interchangeably, not only causing confusion but also giving rise to expectations. In the United States, community nurse practitioners worried that without clarity between the terms, the value of their work as compared with those in institutional service would not be recognized (Barnes et al., 1995). In Serbia, which became an independent country in 2006, and which had made a commitment to follow

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

PHC principles, the health system still struggled to address the goals of equity and good quality healthcare (Simi´ca, Mili´cevi, Mateji, Marinkovi, & Adams, 2010).

In an attempt to clarify the relationship of PHC to primary care, the Commission on the Social Determinants of Health included this statement in its 2008 report:

The Alma Ata declaration promoted Primary Health Care as its central means toward good and fair global health—not simply health services at the primary care level (though that was important), but rather a health system model that acted also on the underlying social, economic and political causes of poor health.

(Commission on the Social Determinants of Health, 2008, p. 33)

In promoting Universal Health Care (UHC) as the key WHO policy in 2017, Tedros (Ghebreyesus, 2017) made it clear that equity and community participation constitute the framework in which a healthcare system must be rooted.

## **Translating Equity and Community Participation From Rhetoric to Reality**

### **Equity**

Health inequities have been defined as “differences in health that are unnecessary, avoidable, unfair and unjust” (Whitehead, 1992). *Inequity* is not the same as *inequality* because inequity is an ethical concept based on social justice and linked to human rights, whereas inequality is only descriptive. Equity can be defined and measured by examining groups that have different advantages depending on their position in the social hierarchy, highlighting their possibility of accessing good health because of environment, income, lifestyle, and access to health services and healthcare. Measuring health disparities and inequalities without disaggregating the population in terms of social conditions makes it impossible to identify which groups have worse health outcomes and why they might have these outcomes (Braverman & Gruskin, 2003).

The Commission on the Social Determinants of Health (2008), in its third recommendation, called for the need to measure and understand the causes of poor health and assess the impact of actions to be taken to correct problems (p. 2). It recommended, among other actions, that governments develop a health-equity surveillance system in their own countries and as a contribution to a global surveillance system, that research budgets dedicate money to collect and share information about social determinants of health, that the training of medical and health professionals incorporate social determinants of health as compulsory training, and that governments

## Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years

---

create the capacity for planners and managers to have information about health equity impacts through impact assessments (p. 206).

Although support for and interest in measuring health inequities has expanded, identifying and taking action in interventions to change these conditions has not been easy. A systematic review of how the equity of health interventions was being accessed highlighted the difficulty of measuring equity because of the lack of clear definitions of which health conditions are avoidable and which effects could be related to the fairness of distribution of healthcare. As a result, the authors found that most researchers used the term “inequality” to assess effects of interventions on disadvantaged groups (Welch et al., 2009). In 2012 *The Lancet* published an article that reanalyzed data for 12 maternal, newborn, and child health interventions from national surveys done in 54 countries between January 1, 2000, and December 31, 2008. The authors used the standard wealth index and household wealth for their calculations, and then used specific child-health indicators in making their assessments. In 2013, WHO published a handbook for measuring health inequalities focused on low- and middle-income countries. It stated that measuring health inequalities was an indirect means by which to assess health inequities, and it produced a list of factors that to consider in assessing equity that would modify findings of the inequality data. Referred to by the acronym PROGRESS, these factors included **P**lace of residence (urban, rural, etc.), **R**ace/ethnicity, **O**ccupation, **G**ender, **R**eligion, **E**ducation, **S**ocioeconomic status, and **S**ocial capital or resources (WHO, 2013)

### Community Participation

The principle of equity found traction for implementation in PHC policy and programs; however, the principle of community participation struggled. Whereas equity could be examined with quantifiable data showing which population groups got what services, as well as the impact of specific social determinants of health such as income and education, community participation lacked any frameworks for identifying and evaluating its impact. One of the reasons was that it was difficult to agree on definitions of “community” and “participation.” In the field of health, the term *community* has most often been defined as people living within a specific geographic border. Yet experience and common sense show that communities can also be people who share a common goal or belief, people who share a common culture or value system, and people who are defined by planners as having common interests (MacQueen et al., 2001). These obstacles made it difficult to apply the traditional scientific framework of randomized controlled trials to standardize its value (Atkinson et al., 2011; Mubyazi & Hutton, 2012). Randomized controlled trials are useful for assessing interventions that take a replicable approach to solving a problem. But it has been argued that community participation is a context-dependent process and therefore subject to unpredictable outcomes (Rifkin, 2014).

Another reason community participation lacked identification and evaluation frameworks was that the value of community participation was based on a number of assumptions for which there was scarce and questionable evidence. These assumptions included that (a) it

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

was not necessary to define “community” and “participation” before a health intervention began; (b) people wanted to be involved in decisions that affected their health and healthcare; (c) giving information to people about how to improve their health resulted in positive behavioral change; and (d) the provision of information would empower people and would result in the behaviors the professionals who gave the information had expected to see (Rifkin, 2009, 2012). The World Bank published a study of the contributions of community participation in development programs, including health in low- and middle-income countries. It concluded that despite the bank’s investment of about \$85 billion over a decade (2003–2013), expectations of improved outcomes were “arguably still driven by ideology and optimism more than by systematic analysis, either theoretical or empirical” (Mansuri & Rao, 2013, p. 3).

Another major weakness in the collection of evidence to relate benefits of community participation to health improvements was that issues related to power and control were rarely considered. Health research most often focused on the technical mechanisms of participation instead of more inclusively investigating social and political factors. The discussion about whether participation was a means or an end in health improvement (Morgan, 2001) highlighted the question of whether the value of participation was to mobilize communities to take actions defined by professionals or whether the value was to empower communities to make their own decisions about how to improve health. Few publications examined power and control in participatory health programs with communities (George, Mehra, Scott, & Sriram, 2015). And policymakers rarely explicitly addressed this question. Only recently, in the *Bulletin of the World Health Organizations* (Marston et al., 2016), have WHO staff members examined this topic. They concluded that power must be identified in communities if the transformation to sustainable health actions and programs is to succeed.

### **Community Health Workers**

These challenges became apparent as programs were developed to incorporate the principle of participation into PHC. An early focus, in the wake of Alma-Ata, was the creation of national Community Health Worker (CHW) programs. Inspired by China’s “barefoot doctors,” local people who were taught basic healthcare and seen as “agents of change” in the new People’s Republic of China, CHW became a mantra and was often used interchangeably with the term PHC (Mburu, 1994). The early programs, however, were not sustainable (Berman et al., 1987; Walt, 1990). Reasons included the unexpected costs of training and maintaining this new cadre of health providers and the question of whether they would be considered government employees. However, the early experience of CHWs did not discourage policymakers, managers, and health providers to abandon the idea. Over the next 40 years, governments, international organizations and nongovernment organizations (NGOs) continued to experiment, seeking ways to bring essential service delivery and community ownership to these health programs. There was growing crisis in the health workforce, particularly in Africa, documented in the *World Health Report 2006* (WHO, 2006B) and related to the loss of personnel due to the HIV/AIDS epidemic and the migration of professionals to areas where better salaries were

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

possible. This led to an acceleration of the momentum to train and employ CHWs. In a meeting in Ethiopia in 2015, several UN organizations, including WHO and UNICEF, made recommendations for expanding and institutionalizing the CHW programs of national governments as a key to meeting the Sustainable Development Goals (Dessalegn et al., 2015).

CHW programs faced multiple questions (USAID & MCHIP, 2013). These included (a) Who was a community health worker? Issues around gender (although most were women), age, education, and selection were critical to this answer. There was no agreed upon definition, in good part, because local choices reflected local situations. There were also issues around how workers were chosen because they could be chosen by the government or health professionals, by community leaders or community people. (b) What training and support do they need? CHW programs responded to the context in which they were conceived. This situation was true of both government programs that served different areas in the country and NGO programs, which in comparison served smaller areas. In reality, this situation meant that types of training varied; there was no standard for time and length of training, and backup and supervision varied. (c) What were the financial implications for a CHW program? In many early programs, CHWs were seen as volunteers and did not receive financial remuneration. Experience showed, however, that this approach was not sustainable. The failure of these programs in the 1980s illustrated that it was necessary to clearly define the monetary support needed for these workers, including start-up investment costs, including training, operating costs, and educating communities to accept and support CHWs and recurring costs, including supervision and support in terms of guidance and recognition of value from the existing health system and monitoring and evaluating the program. (d) Could CHWs be both service providers and facilitators for community health improvements? Crystallized in an article by David Werner (1981) entitled "The Village Health Worker: Lackey or Liberator?" this question highlighted the tension between limiting the role of local people being merely service extenders and or having them serve as facilitators in empowering communities to make decisions themselves about health and healthcare. The challenge focused on the role of community in CHW programs because empowerment of community people was increasingly recognized as key to healthcare improvement and sustainability (Black et al., 2017)

### **Social Accountability**

The issues of power and control more recently have focused on issues around social accountability, specifically on the public provision of healthcare for citizens, particularly those who are poor and often marginalized. Public protests were the earlier form of this accountability, an approach perhaps most publicized by the chemical spill by Union Carbide in Bhopal, India, in 1984. The spill officially killed 5,295 people. To date, compensation costs for this disaster in terms of medical care, environmental destruction, and punishment of Union Carbide have not been met. A protest in 2014 led by social activists continued to call attention to these demands (Suderarajan, 2016).

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

In the context of PHC, a more nuanced approach to social accountability between public health-service providers and their patients has been Health Facility Committees (HFCs), created to formalize the interaction of these two groups. A review of these committees in West Africa and Central Africa showed that there were discussions about problems with service delivery and some results showing improvements in staff being present at the facility and in replacing staff that did not perform adequately. The study found that success of these HFCs depended on individuals at the facility, the HFC leadership, and how the committees functioned with other community structures. In addition, because there was no formalized structure and no clear mandate for the HFCs in the planning, monitoring, and supervision of services, opportunities to maximize their potential and include marginalized groups were missed (Lodenstein, Mafuta et al., 2017)

NGOs have broadened the context of social accountability by focusing more on the role of community members and their potential to influence public health providers. The Open Society Foundations have supported efforts to have communities move from public protests to engagement with the service providers with whom they interact (Headley, 2014). As part of this process, a range of tools for community people have been developed. Among the most popular are:

- 1.** Community scorecards used by community members who themselves carry out qualitative evaluations concerning public services, institutions, or projects and then meet with the service providers to share their findings.
- 2.** Citizen report cards used by community members in surveys that provide quantitative results on the quality and accessibility of services by those who are the users.
- 3.** Social audits used by community members to assess the impact of government projects and services and look at the differences in proposed and real benefits, to identify unexpected challenges and negative effects of project implementation.

Although the use of the tools is expanding and communities are finding ways to assert their concerns to health providers, the tools do not provide a blueprint for social accountability in health. An investigation into 37 social-accountability programs in 15 countries found that “health provider receptivity to citizens’ demands for better healthcare is mediated by health providers’ perceptions of the legitimacy of citizen groups and by the extent to which citizen groups provide personal and professional support to health providers” (Lodenstein, Dieleman et al., 2017, p. 125). A context in which the health provider is an activist for change, believes that his or her role can bring about that change, and allies with the community groups creates an environment that makes change possible. There are no recipes for success.

## **Financing PHC**

### Donor Aid

In all countries, the ability to provide healthcare and health services depends on political commitment and financing. In the 40 years since the Alma-Ata declaration, this challenge has become more pressing because populations have increased, and medical technology and the resultant interventions, including pharmaceuticals, have enabled people to live longer, healthier lives. The equity principle of PHC focused on making interventions available to everyone regardless of the ability to pay. To reach this goal, in part, means having the resources to provide services and care. Compared to low- and middle-income countries, high-income countries allocate a greater proportion of their budgets to health. It has been estimated that in 2015, low-income countries spent \$0.03 for every dollar spent in high-income countries and that by 2040, only 3% of 34 low-income countries and 37% of 98 middle-income countries will achieve the Chatham House goal of spending 5% of the gross domestic product on health (Deileman et al., 2016A). In low-income countries, where budgets are below 5%, donor aid has been critical. Between 2000 and 2009, donor aid increased at a rate of 11.3%. Yet between 2010 and 2015, annual contribution grew at 2% (Dieleman et al., 2016B)

Aid has leaned toward the vertical approach, often targeting specific diseases such as HIV/AIDS, a major concern in African countries. One reason is that this approach has clear targets, making progress visible in the short term. Horizontal approaches need more time to show success, and it is more difficult to prove that the inventions directly produce health improvements. Financing healthcare continued to be a challenge that dominated policy and programs and demanded creative thinking.

### Universal Health Coverage

In the context of PHC, UNICEF together with the Bamako Initiative undertook one of the first approaches to provide financial support to low- and middle-income countries. The idea was to give drug kits to poor communities and for the communities to sell them for profit. The money earned would then be invested in community development projects (Mehrotra & Jarrett, 2002). Plagued by the problems of poor local infrastructure, lack of government support, and corruption, the Initiative gained little traction for expansion or scaling, and user fees reduced the uptake of services (McPake, 1993). One viable alternative that attracted growing interest was community-based health insurance (CBHI). In an attempt to reduce catastrophic out of pocket payments for the poor, CBHI provided a voluntary nonprofit scheme in which community members contributed to get coverage from a local health unit. Payment was made in cash or kind and was based on risk pooling and the mutual trust and solidarity of group members. This scheme became popular in Africa, where poor rural communities were identified as potential recipients. However, evidence suggests that most of these programs had limited coverage and small risk pools and were exposed to bankruptcy. CBHI programs were only possible when they

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

were complementary to other more established health financing programs (Ekman, 2004).

The impact of the 2008 global financial crisis on healthcare in all countries became a focal point of discussions about healthcare financing. After the call for a renewal of PHC in *World Health Report 2008* (WHO, 2008), evidence of the need to provide healthcare to people that was accessible, affordable, and acceptable was put forward in 2010, in *World Health Report: Health Systems Financing: The Path to Universal Coverage* (WHO, 2010). Using the principles of community participation and equity as its foundation, the report called for a commitment by member states to address the following barriers: (a) lack of resources for healthcare, (b) out-of-pocket payments, which impoverished the already poor, and (c) inefficient and inequitable use of the available resources. The solution was to have countries address the issues around inefficient tax collection, budget priorities, and limited approaches to raising revenue. The report also called for assistance to low- and middle-income countries in an effort to help them develop sustainable financing programs. It called for the creation of national insurance programs that would reflect country contexts and build risk pooling to ensure that the poor would no longer be vulnerable to catastrophic expenses; make pre-paid payments compulsory; and allow for cross-subsidization, enabling money to be raised from organizations in both the public and private sectors. Innovative approaches based on equity and community involvement were critical for success. One result was that the CBHI programs began looking attractive as a way forward. Both Ghana (Blanchet & Acheampong, 2013) and Rwanda (Shimeles, 2010) developed CBHI programs that became the basis of universal health coverage (Hong & Peilemeir, 2012).

However, as Kutzin (2012) highlighted in an article in the *Bulletin of the World Health Organization*, implementing UHC poses challenges. Voluntary payments may be one part of a country's UHC scheme, but they are not sufficient to ensure sustainability. Government revenues from general taxation as well as revenues earmarked for UHC must be the foundation for a successful program. And though large pools of contributors are important when the pools comprise specific groups within the country, such as the working population, there is a great risk of inequity. Those not in the workforce will be excluded from benefits. In countries where such fragmentation exists, it is necessary for governments to supplement explicitly marked funds to ensure equity. UHC can only work when a country has the structures, skills, and data to ensure that all people are covered. His conclusion is that the context is important and that, though lessons can be learned from across-country experiences, there is no blueprint.

## **From Policy to Practice: Examples From Africa, Asia, and Latin America**

## The Search for Evidence

The challenges discussed here present obstacles to implementing PHC as the national policy of governments. As many publications have highlighted, a “political will” to overcome these obstacles is needed (World Health Organization, 1978, p. 5), defined in the *New Oxford American Dictionary* online, as

political intention or desire (in early use not as a fixed collocation); (later) specifically the firm intention or commitment on the part of a government to carry through a policy, especially one which is not immediately successful or popular. (*Oxford Living Dictionaries*, s.v. “political will.” )

Political will is contextual and also depends on a dynamic process to enable new approaches to old problems. In the case of PHC, this process includes mobilizing support at local levels to provide evidence for policy change. It has also included the experiences of governments that have tried to implement PHC as national policy. Examples of successes and failures provide concrete illustrations of the process of putting policy to practice (Bababanova, McKee, & Mills, 2011).

Since accepting PHC as national policy, governments and NGOs throughout the world have taken up the challenge of turning the vision of PHC into viable, sustainable programs. Where PHC has found more fertile ground for its seeds has been in low- and middle-income countries that carry the larger burden of disease and have fewer resources for addressing overall health problems. It also can be argued, as Starfield (1998) suggested, that it is in these countries that circumstances and experience have created the environment and the need to build on community involvement rather than hospitals to seek sustainable health improvements.

In the field of health, where biomedicine is the necessary but not sufficient basis for improved health status, political will, in good part, particularly depends on having evidence that will support new ways of providing health interventions. In the global policy arena, two groups have been particularly important in collecting evidence that supports the PHC approach. The first is a working group of the American Public Health Association, named the Community-Based Primary Health Care (CBPHC) Working Group, which was started in the 1997. Defining community-based PHC as a process by which health programs and communities together seek ways of improving health and controlling diseases, the group focused on worldwide experience in the community provision of PHC outside health facilities to address health problems of mothers and children (Perry et al., 2017). The group established a Task Force and Expert Panel in 2006 and found funding to expand their investigations and their collection of evidence to include maternal, neonatal, and child health. The findings were published in 2017 in the *Journal of Global Health* (Research Theme 1, 2017).

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

The group reviewed 12,666 published and grey literature reports and through a rigorous methodology and selected 700 that met the inclusion criteria. The investigation found evidence supporting the value of the CBPHC approach (Black et al., 2017). From these results, it was estimated that the number of perinatal, maternal, neonatal and child deaths that could be avoided annually by community-based health packages was 2.3 million; from PHC facilities, the number was 0.8 million; and from hospitals, it was 0.9 million. The report also highlighted the important role of CHWs in both underpinning and promoting better use of services and behavior changes. Policymakers, however, did not take up the evidence presented by the CBPHC project. Goal 3 of the Sustainable Development Goals of WHO and UNICEF is to

by 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births; by 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

(United Nations Development Programme, N.D.)

The role of CBPHC was not acknowledged (Black et al., 2017).

A second global actor in the advocacy of the PHC approach was the Peoples' Health Movement. Established as an organization of diverse national groups in both the industrial and less-industrial countries, the group's 2000 charter binds civil society and these organizations together through a commitment to upholding the PHC principles of the Alma-Ata declaration defining health as a human right and equity, people's participation, and intersectoral collaboration as fundamental to supporting this right (People's Health Movement, 2000). With funding from the Canadian government and coalition partners in Canada and other countries, a research project was undertaken from 2007 to 2011 by 20 research teams in 15 low- and middle-income countries. The objectives were to (a) strengthen research capacity in low- and middle-income countries, (b) research the progress being made toward CPHC in these countries, and (c) build links between researchers and decision-makers in each country (Labonte et al., 2014).

Recognizing contextual differences, the research identified specific health-system characteristics that could be transferred to support and maintain CPHC practices. These included the presence of well-trained and well-supported community healthcare workers to improve health in marginalized communities; effective mechanisms for community participation, both formal, in structured organizations, and informal, in projects, programs, and consultations; co-partnerships of local organizations and governments that could provide knowledge and financing, but retaining decision-making in local communities; and community advocacy support for decision-making in social and health systems. In conclusion, the synthesis of the research addresses some of the challenges discussed in the section entitled Defining and Translating PHC into Practice. It argued

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

that with the move toward universal health coverage, the political commitment to community-based PHC is necessary to sustain and move forward based on the contributions identified in the research and to revitalize the key PHC principles of equity and participation based on human rights for health (Labonte et al., 2014).

In addition to the PHC experience in comparatively small projects, several national governments have taken steps to create a PHC approach to healthcare delivery. Their experiences are also contextual and therefore not able to provide blueprints. However, their experiences identify areas of success and challenges. The experiences of the programs of three national governments from three different geographic regions provide examples of how government commitment influences the PHC approach to health improvements.

### **Brazil**

In Brazil, the history of the health reform that developed key elements of a PHC approach dates back to the opposition to military rule (1964-1985). During this period, a loosely organized coalition called the Public Health Reform Movement was created, which focused on democratic reform of the health sector and began to realize this objective with the fall of the military government (Collins, Araujo, & Barbosa, 2000). A CHW program that began in the 1990s was integrated into the Family Health Strategy developed after the government mandated that universities adopt new curriculum as part of an effort address the health needs of a majority of poor people in the country. The Family Health Strategy which Family Health Teams were the core was adopted in 2007 and incorporated intersectoral programs to address health needs. In 2012, these teams covered 52% of the population and were deployed based on government priorities. Family Health teams consist of one doctor, one nurse, one nurse assistant, and between four and six CHWs. Teams addressed clinical, public health, health promotion, and social issues. The teams made household visits and participated in local health councils. All providers undertaking these tasks were governed by a standard set of rules. The government paid 48% of the budget; the remaining funding came from private providers. There were no user fees or informal payments required at the facilities (HEPCAPS1 Project Team, 2012).

The Brazilian experience had some success in creating a healthcare model based on principles of PHC. The model has made progress toward equity and in community participation. It has one of the strongest integrations into the national health service of any country (Perry, 2016). It also faced challenges. The resistance of the medical profession to train lower-level workers in health services that are accessible and acceptable to the community is still a barrier, as is financing the model. Specific challenges include:

- 1. Integrating traditional vertical healthcare programs into the new horizontal model, with the result that some of these programs are delivered outside team activities.**

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

2. Managing teams in 5,500 municipalities where the capacity of a decentralized governance system is still in the beginning stages.
3. Training the necessary staff to deliver primary care when universities resistant to change still have no family medicine departments, despite government funding for these studies.
4. Incentivizing better-off families to invest in state insurance schemes, and not support private sector health, which has resulted in overlapping health coverage and unnecessary spending (HEPCAPS1 Project Team, 2012).

In the long term, there are the problems of a growing shortage of doctors and questions about the government's commitment to focusing healthcare expenditures on equity and quality of care (Perry, 2016). The current political crisis starting in 2014 with corruption charges against the sitting President is a complicating factor in the future of the program.

### **Ethiopia**

Ethiopia, like Brazil, experienced positive gains in healthcare and service provision based on PHC. The country's history, like that of Brazil, is one in which an existing military dictatorship was replaced by a democratically elected government, in Ethiopia's case in 1995, which resulted in the new government taking steps to address the existing inequality in the population's access to healthcare and an improvement in the quality of services. A key to the health strategy was the creation of the Health Extension Program based on Health Extension Workers (HEWs), chosen by local communities, with a view to engaging and empowering those communities to demand and participate in the development of healthcare and health services. Begun in 2004, by 2012 the program had trained 38,000 HEWs, of whom 34,000 were in rural areas and 4,000 were urban. Their work was supported by volunteers, who were "model families" willing to adopt health and behavioral changes, and whom the district office promoted as "examples" to other community members. These volunteers, who were mainly women, are known as the Health Development Army and they augment the HEWs (Admasu, Balcha, & Haileyesus, 2016).

Before that, in 1988, a new health financing strategy was developed that allowed health units to retain revenue and use it to improve the quality of service; it also established health-facility governing boards, fees based on willingness to pay, and a pay-waiver system for the poor (Feleke, Mitiku, Zelelew, & Ashagari, 2015). In the same year, CBHI schemes began to generate additional critically needed revenue. These schemes aimed to increase resources for the health sector, strengthen community participation in health service, and build the national capacity to bring health insurance coverage to those in the informal sector (HEPCAPS1 Project Team, 2012).

The Ethiopian experience has received much attention. The current director-general of WHO was the Ethiopia's health minister from 2005 to 2012, a period of major reforms. Ethiopia's success highlights both the ways in which equity has been addressed and the expansion of community participation in healthcare, not only in terms of CHWs but also

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

the involvement in advocacy and decision-making. Ethiopia met some of the Millennium Development Goals, achieving a 67% reduction in under-five mortality, a 90% reduction in HIV infections, a 73% reduction in malaria-related deaths, and a 50% decline in mortality due to tuberculosis. Assefa, Van Damme, Williams, and Hill (2017) argue that this was possible because of intersectoral collaboration and the progress that is being made toward achieving the other goals, including with respect to education, water and sanitation, and poverty reduction. The stability of government under Meles Zenawi (1995-2012) who died in office in 2012 and his acting successor, Hailemariam Desalegn was also a factor.

However, challenges remain. Although the expansion of skilled workers has been laudable, there still lack of sufficient attention to improving the quality of care (Bogale, 2017). The attention given to expanding the numbers of CHWs has not been repeated at higher levels of staff recruitment, particularly of mid-level workers, technical staff, and doctors. Financing remains a big problem, creating a continuing need to depend on external funding (HEPCAPS1 Project Team, 2012). Perhaps more concerning about how the experience of Ethiopia and PHC is being understood is the failure of many publications to take the political context into account. In an article entitled “The Silencing of Political Context in Health Research in Ethiopia: Why It Should Be a Concern,” the authors argue that the positive picture of health achievements rarely reflects the country’s governance by an authoritarian state that challenges, among other values, the PHC ideals of social justice. To understand the reality of Ethiopian success, they say, it is necessary to investigate the complexity of these gains to assess how they were made and at what cost (Østebø, Cogburn, & Mandani, 2018).

### **India**

The Indian pursuit of PHC principles of equity and participation dates back to 2004 and before, to the election of the left-leaning coalition Universal Progressive Alliance. Citing a major concern over health and a commitment to improving the lives of India’s rural, mainly poor population, which at the time was around 70% of the population of the entire country, the government, in 2005, established the National Rural Health Mission (NRHM). The development and management of the NRHM grew out of a unique arrangement that included both government bureaucrats and members of NGOs. The NGO members belonged to a coalition under the umbrella of the Peoples’ Health Movement, whose commitment to social justice and the empowerment of the intended beneficiaries of healthcare is described in the section entitled From Policy to Practice: Examples from Africa, Asia and Latin America: The Search for Evidence. The NRHM sought to provide universal access to equitable and affordable healthcare, with an emphasis on care for mothers and children. Established after a pilot program in the state of Chattisgarh, it was expanded to 18 of the poorest states in the country. The program provided money for most of the programs in the health sector and flexibility in their use in order to integrate service provision with the newly established health and sanitation committees in each village. These committees were to be the decision-making bodies at the local level concerning healthcare allocations (Government of India, 2010A). A key

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

component of the program was the reinvented CHWs called the Accredited Community Health Activists (ASHA). ASHAs were women chosen by the community to support the new program with activities ranging from transporting pregnant women to health facilities to give birth (in some states, there was a fixed fee for this service) to providing health education and motivation for behavioral changes. To support this new provision of healthcare, the government announced an allocation of from 2% to 3% of the gross national product, expanding funds from the previous 1.1% (Government of India, 2010B).

The five-year review of the NRHM showed impressive gains in health improvements. The infant mortality rate declined from 58 per 1000 live births in 2003 to 39.1 per 1000 in 2018. The maternal mortality rate declined from 300 per 100,000 live births to 174 per 100,100 in 2015 (Index Mundi, 2018). Upgrading physical infrastructure and providing more staff resulted in 91% of normal births being performed in health units (Government of India, 2010). Yet despite the government's commitment, both in action and finances, there was no universal blueprint print for organizational structures, community commitment, and financing in the NRHM operation. A major challenge was finding agreement on how to define the Mission's achievements. The bureaucrats wanted quantitative assessments of the health improvements that community-based healthcare was providing. The NGOs wanted to value the interventions in terms of community empowerment. Harking back to the question of whether community participation was a means or an end for health improvement, described by Morgan (2001), the question of whether an assessment of the program should only identify the gaps in service provision or whether it should change the power relationship between the government and local people to enable the community to decide how best to meet the needs they have defined. The challenge to the institutional norms of the health sector suggested that the community approach needed more time to realize its potential (Gaitonde et al., 2017). In addition, a new government, led by Narendra Modi of the conservative Bharatiya Janata Party, reduced funding for the health sector to 1.5% of gross national product. Although an agreed upon definition of PHC focused on equity and community participation had created a mutual understanding between the government and various groups working in the health sector, putting the PHC values into practice has not had the time or money to become entrenched as an accepted approach to meeting health needs (Gaitonde et al., 2017).

## **PHC: Looking Toward the Future**

In 1978 Alma-Ata conference introduced a visionary way of examining how to address unmet basic health needs in practical, culturally appropriate, and scientifically valid ways. This vision stimulated an entirely new discussion about how to realize the WHO definition of health. One result was an increasing concern about equitable access to healthcare and about the necessity of including the intended beneficiaries of care in decision-making about their health needs and concerns. That dialogue resulted in a

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

variety of experiences that included frameworks to investigate social determinants of health impacts and outcomes and evidence supporting strengthening the systems that delivered health interventions. These efforts included investigations into the distribution and availability of resources and the expansion of CHWs at the community level to meet local health needs. There is evidence of growing interest in and success of programs that pursued these principles. The Rockefeller Foundation published a report entitled *Good Health at Low Cost: 25 Years On; What Makes a Health System Successful?* It reviewed the experiences of 10 countries and two states in India that showed how a PHC approach can relatively rapidly improve the health of low-income populations in a cost-effective and sustainable way (Bababanova et al., 2011). A recent meeting in South Africa in 2017, sponsored by UNICEF and the United States Agency for International Development (USAID) in collaboration with WHO and the Bill and Melinda Gates Foundation, on institutionalizing community health highlighted the need to build strong community health systems; empower local people, including CHWs; and build links to other sectors to ensure health for all in the WHO definition (Zambruni et al., 2017).

This article has identified critical challenges to PHC. PHC emerged and developed in a global environment at a time when a shared commitment to reducing poverty and pursuing democratic principles was high on the world agenda. Forty years later, this environment is not the same. At the time PHC was accepted as global health policy, health and education were beginning to be identified as public goods to create and promote development, particularly in poor countries (Myrdal, 1968). In the succeeding years, globalization based in large part on neoliberal economic ideas became increasingly important in promoting development goals. Middle- and low-income countries described in this article, as well as in industrial countries such as the United States and Great Britain, saw movements that supported tax reductions to stimulate individual economic growth rather than investments in human capital. Although resistance to globalization has challenged this economic approach, global political instability produces uncertainty, and fragmented approaches to how progress and improve living conditions, including health, can be achieved.

The future of PHC will be defined by the way policies are developed to address two critical concerns. The first is how PHC will influence the direction of the most pressing health issues. An overarching concern is climate change and what its effects on health, healthcare, and health improvements will be (Horton & Lo, 2015). There are also pressing and immediate issues about the control of noncommunicable diseases, global health emergencies such as Ebola and Zika, and the cost and effectiveness of humanitarian aid in light of the increasing violent disturbances in several countries, particularly in the Middle East and Africa. Underlying the solutions to these concerns are issues around governance. These issues focus on local, national, and international rules and regulations and the ability of supranational organizations such as the United Nations to monitor and enforce multilateral approaches not only to health but also to other social, political, and economic issues.

## Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years

---

The second concern is how the challenges identified in this article will be confronted. The PHC vision, as noted, was shared by a majority of national governments. There was agreement that social justice, equity, and community participation were key to bringing about health improvements for the world's population. However, implementing these shared values encountered serious barriers because, in great part, there was an assumption that a linear, generalizable model for interventions existed that would produce predictable outcomes based on those values. But this assumption was not valid. Researchers today are beginning to focus on complexity theory, which examines history, context, and adaptive solutions in specific situations. Success is an iterative process, depending on how people (decision-makers, managers, intended beneficiaries) adapt to circumstances as they exist in real time, not as was predicted (Bloom & Wolcott, 2012). How PHC evolves will depend on how its values are translated into health and development programs and how their success is evaluated in outcomes. Experience has shown that PHC is not a package of health interventions but a process of addressing health improvements. Viewing the issues in context and examining them in terms of complexity has the potential to increase understanding of the contribution of PHC to translate WHO's definition of health from hope into practice.

### Suggested Reading

Bryant, J. H., & Richmond, B. (2016). Alma Ata and primary health care: An evolving story. In S. R. Quah (Ed.), *International encyclopedia of public health*. London, England: Academic Press.

Brown, T., Cueto, M., & Fee, E. (2006). The World Health Organization and the transition from "international" to "global" public health. *American Journal of Public Health*. January.

Hoffmann, K. D. (2014, June). *The role of social accountability in improving health outcomes: Overview and analysis of selected international NGO experiences to advance the field*. Washington, DC: CORE Group.

*The Lancet*. (2008, September 13). Alma Ata 30 years on: "Health for all need not be a dream buried in the past." *The Lancet*, 372, 917-927.

Newell, K. (1975). *Health by the people*. Geneva, Switzerland: World Health Organization.

Ramalingam, B. (2013). *Aid on the edge of chaos*. Oxford, UK: Oxford University Press.

### References

Admasu, K., Balcha, T., & Getahun, H. (2016). **Model villages: A platform for community based primary health care**. *Lancet Global Health*, 4.

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

Assefa, Y., Van Damme, W., Williams, O. D., & Hill, P. S. (2017). **Successes and challenges of the millennium development goals in Ethiopia: Lessons for the sustainable development goals.** *BMJ Global Health*, 2, e000318.

Atkinson, J., Vallely, A., Fitzgerald, L., Whittaker M., & Tanner, M. (2011). **The architecture and effect of participation: A systematic review of community participation for communicable disease control and elimination; implications for malaria elimination.** *Malaria Journal*, 10, 225.

Bababanova, D., McKee, M., & Mills, A. (Eds.). (2011). *“Good health at low cost”: What makes a successful health system?* London, England: London School of Hygiene and Tropical Medicine.

Barnes, D., Eribes, C., Juarte, T., Nelson, M., Proctor, S., Sawyer, L., . . . Meleis, A. (1995). Primary health care and primary care: A confusion of philosophies. *Nursing Outlook*, 43, 7-16.

Berman, P., Gwatkin, D., & Burger, S. (1987). Community-based health workers: Health start or false start? *Social Science and Medicine*, 25, 442-459.

Bhatia, M., & Rifkin, S. B. (2013). Primary health care: Now and forever? A case study of a paradigm change. *International Journal of Health Services*, 43, 459-471.

Black, R., Taylor, C., Arole, S., Bang, A., Bhutta, Z., Chowdhury, A. M., . . . Expert Panel. (2017). **A comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 9. Conclusions and recommendations of an Expert Panel.** *Journal of Global Health*, 7(1).

Blanchet, N., & Acheampong, O. (2013). **Building on community-based health insurance to expand national coverage: The case of Ghana.** Washington, DC: United States Agency for International Development.

Bloom, G., & Wolcott, S. (2012). Building institutions for health and health systems in contexts of rapid change. *Social Science and Medicine*, 96, 216-222.

Bogale, S. (2017). **Ethiopia: The ailing state of health care in Ethiopia’s state-run hospitals: Who takes the blame?** *Addis Standard online*.

Braverman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, 57, 254-258.

Collins, C., Araujo, J., & Barbosa, J. (2000). Decentralising the health sector: Issues in Brazil, *Health Policy*, 52, 113-127.

Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health: Final*

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

*Report of the Commission on Social Determinants of Health.* Geneva, Switzerland: World Health Organization.

Cruz-Oliveria, V., Kurowski, C., & Mills, A. (2003). Delivery of health services: Searching for synergies within the vertical versus horizontal debate. *Journal of International Development*, 15(1), 67-86.

Cueto, M. (2004). The origins of primary health care and selective primary health care. *American Journal of Public Health*, 94, 1864-1874.

Dawson (Lord Dawson of Penn). (1920). **Interim report on the future provision of medical and allied services.** London, England: His Majesty's Stationery Office.

Deileman, J., Schneider, M. T., Haakenstad, A., Singh, L., Briger, M., Reynolds, A., . . . Murray, C. (2016a). **Development assistance for health: Past trends, associations, and the future of international financial flows for health.** *The Lancet*, 387, 2536-2544.

Dieleman, J., Templin, T., Sadat, N., Reidy, P., Chapin, A., Foreman, K., . . . Kurowski, C. (2016b). **National spending on health by source for 184 countries between 2013 and 2040.** *The Lancet*, 387, 2521-2535.

Dessalegn, H. M., Chambers, R. G., Clinton, C., Phumaphi, J., Sirleaf, E. J., Evans, P. . . . Walker, J. C. (2015). **Strengthening primary health care through community health workers: Investment case and financing recommendations.**

Ekman, B. (2004). Community-based health insurance in low-income countries: A systematic review of the evidence. *Health Policy and Planning*, 19, 249-270.

Evidence for community-based PHC in improving MNCH: Research Theme 5 (2017). **Journal of Global Health.**

Feleke, S., Mitiku, W., Zelelew, H., & Ashagari, D. (2015). *Ethiopia's community-based health insurance: A step on the road to universal health coverage.* [Case study]. Health Finance and Governance Project. Washington, DC: Abt Associates for USAID.

Friedlander, E. (2005). **Rudolf Virchow on pathology education monologue, presented at a meeting of the Group for Research in Pathology education, Hershey Pennsylvania.**

Gaitonde, R., San Sebastian, R., Muraleedharan, V. R., & Hurtig, A. K. (2017). **Community action for health in India's National Rural Health Mission: One policy, many paths.** *Social Science and Medicine*, 188, 82-90.

George, A., Mehra, V., Scott, K., & Sriram, V. (2015). **Community participation in health systems research: A systematic review assessing the state of research, the**

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

**nature of interventions involved and the features of engagement with communities.** *PLOS/One*,

Ghebreyesus, T. A. (2017, July 17). **All roads lead to universal health coverage.** *The Lancet* [Online].

Government of India. (2010a). *National Rural Health Mission: The journey so far 2005-2015*. New Delhi, India: Ministry of Health and Family Welfare.

Government of India. (2010b). *National Rural Health Mission: Meeting people's health needs in partnership with states*. New Delhi, India: Ministry of Health and Family Welfare.

Headley, J (2014, May 16). **How social accountability protects health rights.** Open Society Voices. Open Society Foundations.

HEPCAPS1 Project Team. (2012, May 16). *Developing primary health care delivery in lower and middle income countries: Challenges faced and lessons learned; Report on the Expert Policy Consultation July 30 & 31, 2012*. Ethiopia HEPCAPS Series Paper no. 2. Boston, MA, and New Haven, CT: Harvard School of Public Health and Global Health Leadership Institute at Yale University.

Hong, W., & Peilemeir, N. (2012). Community based health insurance: An evolutionary approach to achieving universal coverage in low income countries. *Journal of Life Sciences*, 6, 320-329.

Horton, R., & Lo, S. (2015). **Planetary health: A new science for exceptional action.** *The Lancet*, 386, 1917-2028.

Index Mundi (2018). [https://www.indexmundi.com/india/infant\\_mortality\\_rate.html](https://www.indexmundi.com/india/infant_mortality_rate.html).

Kutzin, J. (2012). **Anything goes on the path to universal health coverage?** *Bulletin of the World Health Organization*, 90, 867-868.

Labonte, R., Sanders, D., Packer, C., & Schaay, N. (2014). **Is the Alma Ata vision of comprehensive primary health care viable? Findings from an international project.** *Global Health Action*, 7(1).

Lawn, J., Rohde, J., Rifkin, S., Were, M., Paul, V., & Chopra, M. (2008). Alma-Ata 30 years on: Revolutionary, relevant, and time to revitalize. *The Lancet*, 372, 917-927.

Lodenstein, E., Dieleman, M., Gerretsen, B., & Broerse, J. E.W. (2017). **Health provider responsiveness to social accountability initiatives in low- and middle-income countries: A realist review.** *Health Policy and Planning*, 32, 125-140.

Lodenstein, E., Mafuta, E., Kpatchavi, A. C., Servais, J., Deileman, M., . . . Toonen, J. (2017). Social accountability in primary health care in West and Central Africa: Exploring the role of health facility committees. *BMC Health Services Research*, 17, 403.

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

MacQueen, K. M., McLellan, E., Metzger, D. S., Kegeles, S., Strauss, R. P., Scotti, R., . . . Trotter, R. T. (2001). What is community? An evidence-based definition for participatory public health. *American Journal of Public Health, 91*, 1929-1938.

Mansuri, G., & Rao, V. (2013). *Localizing development: Does participation work?* Washington, DC: World Bank.

Marston, C., Hinton, R., Kean, S., Baral, S., Ahuja, A., Costello, A., & Portela, A. (2016). Community participation for transformative action on women's, children's and adolescents' health. *Bulletin of the World Health Organization, 94*, 376-382.

Mburu, F. M. (1994). Whither community health workers in the age of structural adjustment? *Social Science and Medicine, 39*, 883.

McPake, B. (1993). Community financing in Africa: An evaluation of the Bamako Initiative. *Social Science and Medicine, 36*, 1383-1395.

Mehrotra, S., & Jarrett, S. (2002). Improving basic health service delivery in low-income countries: "Voice" to the poor. *Social Science and Medicine, 54*, 1685-1690.

Morgan, L. (2001). Community participation in health: Perpetual allure, persistent challenge. *Health Policy and Planning, 16*, 221-230.

Msuya, J. (2004). **Horizontal and vertical delivery of health services: What are the trade-offs? (Working paper, no. 26942)**. Washington, DC: World Bank.

Mubyazi, G., & Hutton, G. (2012). Rhetoric and reality of community participation in health planning, resource allocation and service delivery: A review of the reviews, primary publications and grey literature. *Rwanda Journal of Health Sciences, 1*, 51-65.

Myrdal, G. (1968), *Asian drama: An inquiry into the poverty of nations*. New York, NY: Pantheon.

Oliveria-Cruz, V., Kurowski, C., & Mills, A. (2003). Delivery of priority health services: Searching for synergies with the vertical versus horizontal approach. *Journal of International Development, 15*, 69-86.

Ooms, G., Van Damme, W., Baker, B. K., Zeitz, P., & Schrecker, T. (2008). **The "diagonal" approach to Global Fund financing: A cure for the broader malaise of health systems?** *Globalization and Health, 4*(6), 1.

Orenstein, W. A., & Seib, K. (2016). **Beyond vertical and horizontal programs: A diagonal approach to building national immunization programs through measles elimination.** *Expert Review of Vaccines, 15*, 791-793.

Østebø, M. T., Cogburn, M. D., & Mandani, A. S., (2018). The silencing of political context in health research in Ethiopia: Why it should be a concern. *Health Policy and Planning, 33*, 258-270.

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

- Panda, S. C. (2006). **Medicine: Science or art?**. *Mens Sana Monographss*, 4(1), 127-138.
- Perry, H., B., Rassekh, B., Gupta, S., Wilhelm, J., & Freeman, P. (2017). **A comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 1. Rationale, methods and database description**. *Journal of Global Health*, 7(1).
- Perry, H. B. (with Akin-Olugbade, L., Lailari, A., & Son, Y.). (2016). **A comprehensive description of three national community health worker programs and their contributions to maternal and child health and primary health care: Case studies from Latin America (Brazil), Africa (Ethiopia) and Asia (Nepal)**. Johns Hopkins University, Bloomberg School of Public Health.
- People's Health Movement. (2000). **The people's charter for health**.
- Research Theme 5: Evidence for community-based PHC in improving MNCH.**  
*Journal of Global Health*, 7(1).
- Rifkin, S. B. (2009). Lessons from community participation in health programs: A review of the post-Alma Ata experience. *International Health*, 1, 31-36.
- Rifkin, S. B. (2012). **Translating rhetoric to reality: A review of community participation in health policy over the last 60 years**.
- Rifkin, S. B. (2014). Examining the links between community participation and health outcomes: A review of the literature. *Health Policy and Planning*, 29, ii98-ii106.
- Rifkin, S. B., & Walt, G. (1986). How health improves: Defining the issues concerning "comprehensive primary health care" and "selective primary health care." *Social Science and Medicine*, 23, 559-566.
- Sepulveda, J., Bustreo, F., Tapia, R., Rivera, J., Lozano, R., Olaiz, G., . . . Valdespino, J.-L. (2006). Improvement in child survival in Mexico: The diagonal approach. *The Lancet*, 38, 2017-2027.
- Shimeles, A. (2010). *Community based health insurance schemes in Africa: The case of Rwanda*. (Working Papers Series No.120). Tunis, Tunisia: African Development Bank.
- Simi'ca, S., Mili'cevi, S. M., Mateji, B., Marinkovi, J., & Adams, O. (2010). Do we have primary health care reform? The story of the Republic of Serbia. *Health Policy*, 96, 160-169.
- Starfield, B. (1998). *Primary care: Balancing health needs, services and technology*. Oxford, UK: Oxford University Press.
- Suderarajan, P. (2016). **Protests mark Bhopal disaster anniversary**. *The Hindu*.

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

United Nations Children's Fund. (2016). *State of the world's children 1996*. Oxford, UK: Oxford University Press.

United Nations Development Programme. (n.d.). **Sustainable development goals**.

United Nations General Assembly. (1974). Resolution adopted by the General Assembly 3201 (S-VI): **Declaration on the establishment of a new international economic order**. Geneva, Switzerland.

United Nations General Assembly. (1979). **Resolution adopted by the General Assembly 34/58: Health as an integral part of development**. Geneva, Switzerland.

**Universal Coverage Day**. (2012). **UN Resolution 2012**.

USAID & MCHIP. (2013). **Developing and strengthening community health worker programs at scale: A reference guide for program managers and policy makers**. Report by the Maternal and Child Health Integrated Program of the United States Agency for International Development, Washington, DC.

Walsh, J., & Warren, K. (1979). Selective primary health care. *New England Journal of Medicine*. 301, 967-974.

Walt, G., & Vaughn, P. (1981). *An introduction to the primary health care approach in developing countries*. London, England: London School of Hygiene and Tropical Medicine.

Walt, G. (Ed.). (1990). *Community health workers in nation programmes: Just another pair of hands?* Milton Keynes, UK: Open University Press.

Welch, V., Tugwell P., Wells, G. A., Kristjansson B., Petticrew, M., McGowan, J. L., . . . Ueffing, E. (2009). **How effects on health equity are assessed in systematic reviews of interventions**. *Cochrane Database of Systematic Reviews*, 3, MR000028.

Werner, D. (1981). **The village health worker: Lackey or liberator?**. *World Health Forum*, 2(I), 46-68.

Whitehead, M. (1992). The concepts and principles of equity in health. *International Journal of Health Services*, 22, 429-445. First published in 1990 by the World Health Organisation Regional Office for Europe (EUR/ICP/RPD 414). Copenhagen, Denmark.

World Bank. (1993). *World development report 1993: Investing in Health*. Washington, DC: World Bank.

World Bank. (2000). *World development report 2000/01: Attacking poverty*. Oxford, UK: Oxford University Press.

## **Health for All and Primary Health Care, 1978-2018: A Historical Perspective on Policies and Programs over 40 Years**

---

World Health Organization. (1978). *Primary health care: Report of the International Conference on Primary Health Care Alma Ata, USSR, 6-12 September 1978*. Geneva, Switzerland.

WHO. (2000). *The world health report 2000: Health systems; Improving performance*. Geneva, Switzerland.

WHO. (2006a, October). **Constitution of the World Health Organization**. Supplement to *Basic Documents* (45th ed.). Geneva: Switzerland: United Nations.

WHO. (2006b). *The world health report 2006: Working together for health*. Geneva, Switzerland.

WHO. (2008). *The world health report 2008: Primary health care; Now more than ever*. Geneva, Switzerland: World Health Organization.

WHO. (2010). *The world health report: Health systems financing; The path to universal coverage*. Geneva, Switzerland: World Health Organization.

WHO. (2013). *Handbook on health inequality monitoring*. Geneva, Switzerland.

WHO. (2017). **Ten years in public health, 2007-2017: Report by Dr. Margaret Chan, Director-General**. Geneva, Switzerland: World Health Organization.

WHO. (n.d.). **About WHO**.

Zambruni, J., Rasanathan, K., Hipgrave, D., Miller, N., Momanyi, M., Pearson, L., . . . Peterson, S. (2017). **Community health systems: Allowing community health workers emerge from the shadows**. *The Lancet*, 5, 9.

### **Susan B. Rifkin**

Department of Health Systems, Management, and Policy, Colorado School of Public Health

