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



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

Importantly, the Declaration of Alma Ata insisted that PHC was unlikely to succeed without the establishment of a New International Economic Order (NIEO) based on ensuring the rights of states and peoples under “colonial domination” to restitution and full compensation for their exploitation and that of their resources; regulation of transnational corporations; preferential treatment for low-income and middle-income countries (LMICs) in areas of international economic cooperation; transfer of new technologies; and an end to the waste of natural resources.³ With the 1980s rise of neoliberal economics, the UN-supported NIEO was abandoned.⁴

In September, 2019, there will be a UN High-Level Meeting on universal health coverage (UHC). UHC is concerned with improved access to quality health services and protection from financial risks associated with health care. However, UHC, unlike PHC, is silent on social determinants of health and community participation. With the global mobilisation behind UHC, the health sector will probably limit its role to Sustainable Development Goal (SDG) 3.8—to achieve UHC. This shift in policy emphasis for the health

sector threatens to minimise its role in promoting other health-related SDGs such as food and nutrition (SDG 2), gender equality (SDG 5), and water and sanitation (SDG 6); and, importantly, the reduction of inequality (SDG 10), promotion of environmentally responsible consumption/production patterns (SDG 12), and mitigation of climate change (SDG 4).

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



In 2018, the 40th anniversary of PHC was celebrated at Astana,⁸ where references were repeatedly made to “quality PHC” when it was clear that primary care was meant—ie, care at the first level of contact with the formal health sector. Formulations such as “primary health care is essential to achieving universal health coverage”⁸ portray PHC as a means to attain coverage of health services, whereas equitable access to basic health services has always been a component of PHC. As stated in the widely supported Alternative Civil Society Astana Statement,⁹ it inverts one of the means to achieving PHC whereby UHC becomes the goal. This signals the risk of further medicalisation and commercialisation of health care under the UHC model.¹⁰ This year a report of a Pan American Health Organization High-Level Commission raised concern that reform agendas exclusively focused on the health sector, centred on medical care services and the expansion of insurance coverage, have displaced public health and the social determination of health.¹¹

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

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

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Defining primary palliative care for universal health coverage



Much has been achieved in advancing palliative care on the global health agenda, but there is more to do. The 2014 World Health Assembly (WHA) committed countries to integrating palliative care into their health systems and WHO was tasked with monitoring progress.¹ By 2017, WHO had updated the definition of universal health coverage (UHC)—Sustainable Development Goal 3.8—to include palliation along with promotion, prevention, treatment, and rehabilitation.² A *Lancet* Commission in 2017 highlighted the global need to take action when 61 million people are living with serious health-related suffering due to uncontrolled pain and without access to an affordable essential package for palliative care.³

The central role of primary care in delivering health for all has been widely accepted since the Alma Ata Declaration of 1978 and the Astana Declaration of 2018 endorsed it further.⁴ In 2019, the focus of the WHA in May and the UN High-Level Meeting in September is on primary care-led UHC and how this can be made a reality by 2030.

Changing population demographics and disease epidemiology mean people are increasingly dying from chronic non-communicable diseases (NCDs) in low-income and middle-income countries (LMICs).⁵ Primary care-led management of chronic diseases, including palliative care, is essential to deliver cost-effective UHC that does not impose financial hardship on people with NCDs.²

Palliative care for all is only achievable if all members of the health workforce who care for people with life-limiting illnesses deliver it—in all health systems, irrespective of a country's income status.⁶ People are mostly at home for their last years of life, so primary care teams provide much of their palliative care. The palliative care delivered by primary care teams is well developed and promoted in some higher-income countries,⁷ but much

less so in LMICs, although the 2018 WHO guidelines are an encouraging start.⁸ Efforts to achieve primary care-led UHC provide an opportunity to ensure that palliative care is being delivered at the primary care level in all parts of the world and to exploit synergies between disciplines.

Palliative care sits comfortably within primary care. Both deal with a wide spectrum of illnesses, not limited to a single disease process. At their best, both recognise the importance of a holistic approach, coordination of care, and person-centred care within a wider context. The clinical competencies and resources to achieve this care are often lacking among health workers, particularly in LMICs.⁹ Incorporating a palliative care approach into primary care addresses health-related suffering in advanced illness while facilitating development of core skills for primary care practitioners even in remote LMICs.¹⁰

Thus, the scope of palliative care within primary care is wide and its development vital to enable UHC, but it needs to be recognised and clearly defined. We propose primary palliative care (PPC) as the internationally adopted term. PPC was first coined in the UK by Roger Charlton.¹¹ The term was consolidated in 2004, when the case was made for the benefits of delivering palliative care within primary care and the need for research and an academic base.¹² In 2011, Weissman and Meier¹³ in the USA defined PPC as “the basic skills and competencies required

Panel: A new definition of primary palliative care

Primary palliative care is palliative care practised by primary health care workers, who are the principal providers of integrated health care for people in local communities throughout their life. It includes early identification and triggering of palliative care as part of integrated and holistic chronic disease management, collaborating with specialist palliative care services where they exist, and strengthening underlying professional capabilities in primary care.