



# Revisiting Alma-Ata: what is the role of primary health care in achieving the Sustainable Development Goals?

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The Sustainable Development Goals (SDGs) are now steering the global health and development agendas. Notably, the SDGs contain no mention of primary health care, reflecting the disappointing implementation of the Alma-Ata declaration of 1978 over the past four decades. The draft Astana declaration (Alma-Ata 2.0), released in June, 2018, restates the key principles of primary health care and renews these as driving forces for achieving the SDGs, emphasising universal health coverage. We use accumulating evidence to show that countries that reorient their health systems towards primary care are better placed to achieve the SDGs than those with hospital-focused systems or low investment in health. We then argue that an even bolder approach, which fully embraces the Alma-Ata vision of primary health care, could deliver substantially greater SDG progress, by addressing the wider determinants of health, promoting equity and social justice throughout society, empowering communities, and being a catalyst for advancing and amplifying universal health coverage and synergies among SDGs.

## Introduction

The Sustainable Development Goals (SDGs) are now steering the global development agenda and are key drivers of international action on social and environmental determinants of health. The 17 goals cover poverty reduction, hunger, health, education, inequalities, sanitation, energy, social justice, the environment, and climate change. Like their predecessors, the Millennium Development Goals, the SDGs include specific targets, but additionally emphasise broader interlinked aspects, such as sustainability and social justice, promoting a more integrated development agenda. Notably, the SDGs contain no mention of primary health care (PHC)<sup>1</sup>—one of the principal strategies for reshaping health care, promoting health-enhancing policies across sectors, and developing more equitable and fairer societies. Sept 12, 2018, marked 40 years since the Alma-Ata declaration, the bold and ambitious statement that proposed PHC as a platform for improving global health.<sup>2,3</sup>

The 1978 Alma-Ata declaration's vision for societal health included reorienting health systems towards primary care and addressing the social and environmental determinants of health and inequality (panel 1). It emphasised social justice and equitable access to health-care services, key elements of the modern universal health coverage (UHC) agenda (panel 2), and advocated for empowering communities to participate in health-care planning and delivery. In October, 2018, the international community will commemorate Alma-Ata in Astana, Kazakhstan, with an updated declaration which reiterates PHC's indispensability in improving health, and emphasises the need for strengthening and sustaining health systems, and achieving UHC.

Nevertheless, will the Astana declaration succeed in advancing the implementation of PHC against a backdrop of 40 years of lacklustre uptake? Despite efforts to revitalise Alma-Ata in 2008, with WHO's World Health Report on PHC<sup>29</sup> and a *Lancet* Series on Alma-Ata,<sup>23</sup> global action remains disappointing. This disappointing uptake stemmed from misinterpretation of Alma-Ata, minimal

political motivation for societal reform, and constrained finances.<sup>14,23</sup> Confusion between primary care and PHC (panel 1) led to criticism that Alma-Ata was too broad,<sup>23</sup> with the misinterpretation arising from the perspective that primary care should be responsible for addressing broader determinants of health and advancing social justice, far beyond the remit of health services. The proposal of selective PHC in the 1980s, focusing on vaccination, growth monitoring, oral rehydration therapy, and breastfeeding, was viewed as a pragmatic approach to implement primary care in resource-constrained settings, but diverged from Alma-Ata's defining principles.<sup>1,30</sup>

In the past decade, attention to PHC's broader principles has gained pace (panel 3). This attention builds on efforts in some countries to embrace elements of comprehensive PHC, including community engagement and participation—eg, in Costa Rica,<sup>77</sup> Brazil,<sup>78</sup> Chile,<sup>79</sup> and as part of family medicine or general practice in many European countries.<sup>56</sup> Building on this momentum, the current focus on UHC is welcome (panel 2), but it is crucial that this focus on UHC does not create a narrow focus on health services, diverting attention away from

## Search strategy and selection criteria

Data for this Review were identified by searches of PubMed, Google Scholar, and references from relevant articles. Search terms included combinations and synonyms of “primary care” and “primary healthcare”, relevant Sustainable Development Goal terms (eg, “poverty”, “education”, “income”), and key concepts (eg, “social determinants”, “community”, “universal health coverage”, “health and human rights”). We supplemented the data with our knowledge of existing publications. Particular attention was given to systematic reviews and high-level publications from UN, World Bank, and WHO, in addition to other agencies and non-governmental organisations. Only articles published in English were included. No date restriction was applied, but preference was given to articles published in the past decade.

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For more on the **Global Conference on Primary Health Care in Astana** see <http://www.who.int/primary-health/conference-phc/en/>

### Panel 1: Primary health care and primary care

#### Primary health care

Primary health care (PHC), as set out in the 1978 Alma-Ata declaration, is a comprehensive approach to health system organisation and intersectoral action for health. It arose from health system inadequacies present in the 1970s, many of which persist today. These inadequacies included the following approaches: disease-orientated technology, which was expensive, promoted consumerism, and delivered minimal wider population benefit; the overspecialisation and lack of person-centred approaches among many health professionals; poor understanding of the importance of health in social and economic development; and inadequate commitment to primary care as the core of health systems.<sup>4</sup> Importantly, Alma-Ata proposed a role for PHC in addressing social and environmental determinants of health, by considering health a human right, equity an essential value, and community participation a necessary condition for a just society.<sup>2,5</sup>

Alma-Ata also first articulated what has since been termed the Health in All Policies approach, which recognised that all sectors have a role in promoting and coordinating efforts to improve health. The PHC approach emphasised responsiveness—adapting to local economic, social, and political realities—with a strong community focus. Importantly, the Alma-Ata declaration highlighted the responsibilities governments have in improving the health of their populations.<sup>2</sup>

Today, these principles remain ever more pertinent with major global efforts underway to promote progress towards them. A diverse range of movements can be accommodated under the PHC umbrella, despite having their own aims, terminologies, and implementation strategies. These movements include intersectoral action for health and Health in All Policies;<sup>6,7</sup> health promotion;<sup>8</sup> addressing the wider social determinants of health;<sup>9</sup> universal health coverage; reducing health inequalities, including early childhood development and life course approaches; and community-focused and person-oriented primary care. Thus, PHC can be interpreted in the modern day as a societal vision for health and development, and a wide platform to engage those diverse movements built upon common key principles.

#### Primary care

Within the health sector, PHC is often implemented through primary care services. These services are a vital component, yet only comprise the service-fronting elements of the broader PHC concept. They are provided to and are in collaboration with populations, and include promotive, preventive, curative, and rehabilitative services; health education; maternal and child health care (including family planning); and immunisation. Primary care is the locus for integrated referral systems that facilitate access to

comprehensive health care, and services are staffed by multidisciplinary professionals. It also integrates public health actions towards improving food supply and nutrition, ensuring safe water and sanitation, and communicable disease control,<sup>2</sup> and should be able to resolve most health needs.<sup>5,10</sup>

Primary care is often misconstrued as involving basic tasks, procedures, and technologies, with complexity within health systems equated with specialist or technologically intensive interventions. In reality, primary care is inherently complex, since it has challenges regarding the delineation of what should and what should not be managed in community settings, flexible rules governing actions (eg, patients' expectations and wishes), frequent adaptation of services, and non-linearity in clinical conditions.<sup>11,12</sup> The complexity is exemplified by the fact that primary care providers have to manage ill-defined clinical symptoms, respond to changes in patients' circumstances and health status, understand social and environmental drivers of health in local communities, and work at the forefront of implementing many health system reforms.

#### The interaction between primary care and PHC

A defining feature of a complex system is how embedded it is in other systems and how it has co-evolved with them.<sup>11</sup> Although primary care is the more visible, service-oriented, centrepiece of PHC, the two are intrinsically linked with mutually reinforcing roles. PHC is a requisite for strong primary care, as it facilitates equitable and intersectoral approaches to health, community-orientated services, and participatory governance structures.<sup>5,10</sup> Low-income and middle-income countries with stronger government commitments to health, and investment in social assistance sectors, provide more comprehensive primary care services and achieve better health outcomes.<sup>13</sup> Additionally, broader determinants of health, including social capacity and education, affect access to and the effectiveness of primary care,<sup>14</sup> and wider principles of equity are associated with stronger health and social welfare systems across countries.<sup>15,16</sup> Conversely, primary care services have a role in fostering wider uptake of PHC. Community-based health professionals, engaging with local groups and registering populations, can identify and draw attention to local determinants of health and community needs, and facilitate intersectoral engagement and linkages, especially through participatory action approaches.<sup>17,18</sup>

However, challenges exist in fostering such interactions. Despite relatively strong primary care, coordination and wider integration remain weak in many countries.<sup>19</sup> The UK and the Netherlands, for example, have strong primary care systems,<sup>16</sup> but each has difficulty integrating them with secondary systems, community, and social care, and in engaging

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communities.<sup>20,21</sup> There are challenges in incorporating health aims within objectives of non-health sectors and overcoming different funding mechanisms and cultures between health and non-health sectors.<sup>22</sup> Beyond the broader principles, best practices for developing interfaces and connections between primary care and PHC, and mechanisms to strengthen them,

remain under-researched and under-documented. Processes of engagement, agreement, and compromise are needed to develop local, context-specific actions for fostering wider PHC approaches and improving the interactions with primary care and other health and social services.<sup>11</sup>

broader PHC principles and the potential to advance many of the SDGs.

The draft Astana declaration<sup>25</sup> identifies PHC as a driving force for achieving the SDGs. However, a clear articulation of how PHC contributes to the SDG agenda is absent. In this Review, we argue that reorienting health systems towards primary care can accelerate achievement of SDG3 (figure 1).<sup>56,79–82</sup> We then build a case for why both primary care and an even broader PHC approach could make essential contributions to achieving many of the non-health SDGs (figure 2), and advocate for countries to engage with the Alma-Ata's vision of PHC as a mean to maximise efforts towards achieving their SDG targets and to capitalise on the synergies among them.

### How could reorienting health systems towards primary care contribute to the SDGs?

Reorienting health systems towards primary care will not only deliver major health gains, but also promote wider sustainable development. In their most basic role, primary care services contribute to achievement of SDG 3 (health), with preventive interventions and treatments, such as vitamin and nutritional supplements, vaccinations, and therapeutic drugs, which can avert many causes of illness and death, especially for children (figure 1).<sup>83,84</sup> Indeed, most basic cost-effective essential interventions identified in the third edition of *Disease Control Priorities* are community or health centre based.<sup>85</sup> Primary care also targets risk factors and behaviours, such as hypertension, low physical activity, poor diet, and harmful behaviours (eg, smoking and alcohol), with benefits for non-communicable diseases (NCDs),<sup>86,87</sup> reproductive and maternal health,<sup>88</sup> and substance abuse-related harm.<sup>89</sup> Primary care delivers health promotion and education interventions, and fosters continuity of care and long-term relationships with health professionals, increasing benefits,<sup>90,91</sup> such as better treatment adherence.<sup>92,93</sup> Primary care coordinates specialty, diagnostic, and hospital care. This coordination protects patients from unnecessary examinations and treatments, and serves as an individual's medical home. Therefore, countries with strong primary care have been found to have better and more equitable health outcomes and greater health system efficiencies.<sup>51,53,56</sup>

Beyond more immediate health-improving actions, primary care can contribute to other SDGs. Poor health associated with infectious diseases, NCD morbidities, and injuries can contribute to impoverishment (SDG 1), might

### Panel 2: Primary health care and the concept of universal health coverage

The Alma-Ata declaration outlined several broad principles, some of which drive the modern universal health coverage (UHC) agenda. It specifically called for health care "made universally accessible" and initiated a visionary, yet ambitious, call for "health for all",<sup>2</sup> by the year 2000. Although "health for all" was not met,<sup>23</sup> including UHC as target 3.8 of Sustainable Development Goal (SDG) 3 has emboldened its ambitions with sharper calls to action—specifically ensuring universal access to high quality, comprehensive health services without impoverishing health-care services.<sup>24</sup> The draft Astana declaration<sup>25</sup> aligns primary health care (PHC) more closely with UHC, stating the importance of quality PHC for effective and sustainable UHC.

PHC and UHC interact in multiple ways. Firstly, with growing recognition that persistent health challenges require substantial health system reform, primary-care oriented health systems have become essential to increase appropriateness and efficiency, by focusing on people and their wellbeing. Strong primary care is essential to expand and sustain UHC, and UHC should promote equitable approaches to health system financing to support their reforms.<sup>26</sup>

Secondly, the importance of addressing the social and environmental determinants of health in relation to the UHC agenda has grown. There are concerns that UHC might focus too much on curative services, which disproportionately benefit wealthier populations.<sup>27</sup> Embedding UHC within the broader vision of PHC is necessary to avoid such unintended consequences.<sup>28</sup>

Finally, PHC's emphases on equity and the right to health support UHC, and adopting and institutionalising these principles are prerequisites for maximising UHC. The benefits of reorienting systems to primary care across the SDGs will be dependent on coverage of the world's most deprived and vulnerable populations. PHC is key to guaranteeing adequate and equitable coverage within UHC.

The Alma-Ata declaration played an important role in the inception of UHC and renewed calls for PHC, including through the Astana declaration, which will be vital for UHC in the modern era, supporting its progress and maximising its impact.

limit education and employment opportunities (SDGs 4 and 8), and contribute to malnutrition (SDG 2). These conditions often affect the most disadvantaged, further increasing inequality within or among countries (SDG 10).<sup>94–96</sup> Primary care is ideally placed to manage conditions that restrict employment or educational opportunities in the short term, but also acts through prevention and early intervention throughout the life course. Primary care is often the setting for services contributing to SDG 2 (ie, zero hunger),<sup>35,97</sup> in addition to diet counselling, promoting physical activity, and weight management in response to the growing obesity epidemic.<sup>98–101</sup> Primary care can also help reduce health and wider social inequalities (SDG 10), since it is more effective than specialist care in addressing the larger unmet

### Panel 3: 10 years of revitalising primary health care?

WHO's 2008 Health Report on primary health care (PHC)<sup>29</sup> marked 30 years of the Alma-Ata declaration and aimed to place PHC firmly back on the global agenda. It outlines PHC reforms for policy makers and was instrumental in translating the Alma-Ata declaration into actions and priorities for the modern global health community. Concurrently, a parallel health system strengthening (HSS) agenda was growing. Recommended policy reforms were structured around the six WHO health system building blocks to achieve health systems objectives of financial protection, better health, equitable service coverage, responsiveness, and efficiency.<sup>31</sup> The PHC agenda has become intertwined with HSS efforts.<sup>32</sup>

The previous *Lancet Series*<sup>33</sup> on Alma-Ata in 2008 highlighted how, following the Alma-Ata declaration in 1978, structural adjustment programmes and neoliberal economic policies had eroded PHC approaches in health systems. The series noted how vertical interventions were developed instead of comprehensive approaches, and how community participation and intersectoral collaboration remained weak.<sup>33</sup> Although the Series reviewed the evidence on key PHC domains, noting key successes,<sup>33,34-37</sup> wider-reaching comprehensive PHC approaches are clearly scarce, under-resourced, and under-evaluated. Reflecting WHO's World Health Report,<sup>29</sup> the Series called for a revitalisation of PHC through better integration of primary care services, prioritisation of equity, management of human resources for health, and improvements in quality of care, community empowerment, and accountability.<sup>38,39</sup>

Given these efforts to re-invigorate PHC, the question is how revitalised has PHC become? There are promising signs, reflected in specific movements encompassing PHC principles, including intersectoral action to address the health challenges that countries face.<sup>40</sup> In 2008, WHO's Commission on Social Determinants of Health<sup>41</sup> and the 2012 Rio declaration<sup>42</sup> encouraged countries to act on the social determinants through intersectoral action and the Health in All Policies framework. Similarly, in Europe, the 2008 Tallinn Charter called for wider health-improving actions and intersectoral action for health, with re-affirmation in 2018.<sup>43</sup> Health has grown as a priority in other sectors. For example, the UN Habitat's New Urban Agenda (2016) mentions health and embraces PHC-related concepts of local democracy, equity, integrated systems, and cross-sector engagement.<sup>44</sup> Global agencies and funders have increasingly adopted key principles of PHC as part of their strategies.<sup>45,46</sup> For example, UNICEF now includes gender equity as a cross-cutting theme;<sup>47</sup> the US Agency for International Development has promoted HSS;<sup>48</sup> the Global Fund to Fight AIDS, Tuberculosis, and Malaria includes the goals of resilient and sustainable health systems, human rights, and gender equity;<sup>49</sup> and Gavi, the Vaccine Alliance mentions equity, HSS, service integration, and community ownership.<sup>50</sup>

Evidence has grown on the benefit of primary-care focused health systems,<sup>51-53</sup> with increased attention to primary care in many recent health system reforms and policies, including Canada<sup>54</sup> and Taiwan.<sup>55</sup> Research on primary care has also shown how stronger primary care, notably the comprehensiveness and coordination elements, is associated with better health and lower inequalities in Europe.<sup>56</sup> Countries are increasingly encouraging comprehensive, person-centred primary care, and community participation.<sup>57</sup> Efforts have been made to incorporate comprehensive PHC approaches in many countries, particularly those with strong government commitments to equity, health, and UHC. Platforms such as the PHC Performance Initiative are bringing together stakeholders, advancing data collection, and learning from country examples. Civil society, such as through the People's Health Movement, references Alma-Ata, and has vocally advocated for better integration between health services and multisectoral approaches to the health improvement and advancement of social equity.<sup>58</sup> There has also been country action, political buy-in, and recognition of the social determinants agenda in the past 10 years,<sup>59,60</sup> and Health in All Policies activities have increasingly been undertaken (and showcased) across the world.<sup>7,61</sup>

These efforts in the past 10 years follow longer-term transitions, which are shaping the PHC agenda. Institutional decentralisation in many countries, including in health, aims to improve efficiency and bring services closer to communities.<sup>62-64</sup> The importance of empowerment and education of women and girls has grown, including within the health sector.<sup>65,66</sup> This empowerment includes efforts to offer gender-appropriate health services, incorporate gender issues into medical education, remove gender-related barriers to access, and, in a few countries, bring gender issues to the mainstream across government sectors.<sup>67-69</sup>

However, major challenges remain. Reforms and government commitments to PHC have not always delivered sizeable gains, especially to vulnerable groups, and there are areas in which little action has occurred. This limited action is reflected in the persistence of substantial health inequalities in many settings.<sup>70</sup> In European countries, inequalities have reduced over the past decade,<sup>71</sup> although other studies in the USA<sup>72</sup> and France<sup>73</sup> point to widening inequalities across populations. Inequalities in under-5 mortality have declined in many, but not all, low-income and middle-income countries (LMICS) since 2002.<sup>74</sup> A study of 64 (LMICs) showed relative inequality has grown in nearly half of the countries since the 1990s, despite greater equity in coverage of key health interventions, potentially reflecting lower quality health services accessed by vulnerable groups and higher exposure to adverse social and environmental determinants of health.<sup>75</sup>

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For more on the PHC Performance Initiative see <http://phcperformanceinitiative.org/>

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Although important global consensus building around the PHC agenda has been done over the past 10 years, robust uptake and rigorous evaluation remain scant, especially in relation to equity, Health in All Policies, and intersectoral action. Much of the evidence comes from high-income countries or interventions with reduced scope in LMICs.

Stakeholder perspectives are often overlooked.<sup>76</sup> The convergence of PHC and the Sustainable Development Goals (SDGs) provides a new opportunity to integrate PHC into policy planning for the SDGs and for a more structured approach to investment, monitoring, and evaluation.

health needs and access barriers faced by deprived populations.<sup>10,81,102</sup>

Moreover, primary care services are large employers, demand an educated workforce, and provide continuing professional and educational development opportunities.<sup>103</sup> This fact can further contribute to SDG 4 (education) and SDG 8 (employment), and, where women comprise a large part of the health system workforce,<sup>103</sup> can promote female empowerment and gender equality (SDG 5). Although health services are large energy consumers and polluters, a large proportion of this energy consumption and pollution comes from hospitals and not from primary care services.<sup>104,105</sup> Community-located care and reduced treatments in hospitals through early prevention can contribute to more climate-friendly health systems (SDG 13).

Primary care also has a growing role in surveillance and monitoring progress towards SDG achievement. Electronic health records are increasingly used to monitor health and determinants of health, and offer benefits over costly and infrequent national surveys.<sup>106–108</sup> Electronic health records can also help document the adverse effects of conflict, including human rights abuses (SDG 16), recognise harms from poor working conditions (SDG 8), and identify and monitor vulnerable individuals,<sup>109</sup> including women subjected to violence, child labour, modern slavery, and human trafficking (SDG 5 [gender equality] and SDG 8 [employment]).<sup>110</sup> Primary care can also act as a referral point for access to other services, including social protection programmes,<sup>111</sup> adult education,<sup>101</sup> and judicial and protection systems for vulnerable populations,<sup>110</sup> thus contributing to SDG 1 (poverty), SDG 4 (education), SDG 5 (gender equality), SDG 10 (inequalities), and SDG 16 (justice).

### How might embracing a more comprehensive PHC approach contribute to the SDGs?

Beyond re-orienting health systems to primary care, the Alma-Ata vision of PHC supports the achievement of the SDGs. The PHC and SDG agendas are linked because they both address the broader determinants of health, through intersectoral action and Health in All Policies, the promotion of equity and social justice, and the empowerment and participation of communities and individuals. Furthermore, PHC and UHC are strongly aligned (panel 2). However, little robust evidence exists on the effect of implementing the wider

principles of PHC (in contrast to interventions and vertical programmes implemented in primary care), mainly because these wider approaches have not been taken up systematically, or evaluation of such initiatives is weak or difficult. Nonetheless, country-level investments in comprehensive PHC approaches have great potential for achieving many aspects related to both health and non-health SDGs (figures 1, 2).

Addressing the social and environmental determinants of health through intersectoral action is central to PHC. The “agriculture, animal husbandry, food, industry, education, housing, public works, communications” sectors were explicitly mentioned by the Alma-Ata declaration.<sup>2</sup> PHC’s efforts to improve the social determinants of health can improve opportunities to advance many SDGs. These opportunities include poverty alleviation (SDG 1), as health and poverty are intrinsically linked.<sup>112</sup> Similarly, nutrition and hunger (SDG 2) relate to poverty and are key determinants of health. Action within commercial and agriculture sectors, in addition to education and access to clean water, are important to access secure, nutritional food sources.<sup>97,113,114</sup> Evidence suggests that improvements in nutritional outcomes from nutrition-sensitive interventions—eg, improving agriculture and food security and conditional cash transfers, are maximised within a broader focus on social and gender equity.<sup>115,116</sup> PHC recognises the importance of education (SDG 4) and full and productive work (SDG 8) as vital for good health,<sup>112</sup> and so necessitates actions to resolve labour market failures, introduce regulatory protections, strengthen trade unions, and improve job security.<sup>117</sup>

Although strengthening primary care services can advance some aspects of SDG 3 (health), only comprehensive PHC approaches can provide the needed public health and intersectoral actions to meet health targets.<sup>27,118</sup> Environmental factors (such as pollution and the built environment) contribute to a fifth of the global burden of infectious, parasitic, neonatal, and non-communicable diseases,<sup>119</sup> and actions to address these factors lie outside the health sector. Regulation and taxes, such as smoke-free legislation,<sup>120,121</sup> tobacco and alcohol taxes,<sup>122–124</sup> and action within the food and beverage sectors,<sup>113</sup> are important, and health-focused urban planning, agriculture, and housing systems are necessary to reduce pollution, chemical hazards, unsafe sanitation, low physical activity (eg, active commuting), injuries, road traffic accident mortality, vector-borne diseases, and homelessness.<sup>125–127</sup>

	Reorienting health systems towards primary care	Strengthening comprehensive PHC approaches
3.1 Reduce maternal mortality	Provides family planning; facilitates access to prenatal care; detects conditions early; refers to secondary care; encourages use of safe delivery options; and manages conditions during pregnancy.	Can improve effectiveness of primary and prenatal care through community engagement; and addresses determinants of maternal health, such as education, nutrition, female empowerment, and sanitation.
3.2 Reduce neonatal and under-5 mortality	Prevents and treats many conditions affecting child health (eg, antibiotics, vaccination, supplements, nutrition); and promotes access to secondary care and child health monitoring services.	Addresses many broader determinants of child health, including healthy homes, education, social welfare systems, and water and sanitation.
3.3 End the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases	Promotes safer sex and sexual education; monitors and provides treatment to prevent mother-to-child transmission of HIV; delivers immunisations; detects and diagnoses conditions early for treatment; promotes treatment adherence; and delivers preventive services.	Undertakes action in sectors such as education, women's rights, sanitation, poverty, veterinary and animal husbandry practices, employment, and housing to address broader determinants of health; promotes pro-health policies including smoke-free environments; includes vector control as a key part of public health; and encourages community engagement for intervention sustainability.
3.4 Reduce mortality from non-communicable diseases	Manages risk factors; detects conditions early; treats and manages conditions; delivers screening programmes; includes mental health services; and provides access to secondary care and therapy.	Addresses wider social and environmental determinants of health and risk factors (eg, education, physical exercise, urban environment, pollution, diet, and work and home environments) by promoting healthy public policies; alleviates some risk factors for mental health conditions (eg, conflict, violence, disaster, abuse, discrimination); and promotes policies that restrict access to harmful substances such as tobacco, alcohol, and firearms.
3.5 Strengthen the prevention and treatment of substance abuse	Provides prevention and treatment; refers to other specialist services; and educates about risk.	Encompasses integrated approaches to care (eg, with social and substance abuse services); tackles broader determinants of health including education, poverty, housing, and employment; and promotes effective regulation and control strategies.
3.6 Reduce deaths and injuries from road traffic accidents	Treats some acute injuries in areas where emergency care is not available; and promotes safety belt and other safe driving practices.	Addresses wider determinants, including urban environment, alcohol regulation, and road safety.
3.7 Ensure universal access to sexual and reproductive health-care services	Provides relevant health-care services; and facilitates access to modern contraceptive methods.	Promotes access as part of wider commitment to UHC and equity in access to health care; addresses gender inequalities and social determinants of health (eg, education, rights) that can reduce access; empowers individuals; and supports integration with wider services.
3.8 Achieve UHC	Advances progress toward UHC by encompassing a comprehensive range of services and interventions; facilitates access to hospital services; (should) be low cost at the point of care; and reduces longer-term health costs through prevention and risk factors management.	UHC agenda advanced as a central component of PHC; embeds UHC actions within wider PHC principles; promotes the reduction of inequalities and ensures equitable access; reduces longer-term costs of health by addressing broader health determinants and through Health in All Policies approaches.
3.9 Reduce mortality and illnesses from hazardous chemicals, pollution, and contamination	Provides education of risks and hazards in the household, work, and environment; and treats acute conditions.	Encourages healthy policies (including in energy, tax, regulation, and housing sectors) that can reduce availability of hazardous chemical and pollution; encompasses good sanitation; and tackles broader determinants of exposure, including poverty and education.
3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control	Delivers education and brief interventions and counselling to encourage smokers to quit; and facilitates access to specialist smoking cessation services.	Health in All Policies and intersectoral approaches (eg, taxation, regulation) foster strong tobacco control policies.
3.b Support the research and development of vaccines and medicines, and provide access to affordable essential medicines and vaccines	A key platform for delivering existing, and testing and evaluating new vaccinations.	Encourages Health in All Policies approaches (eg, education, transport) that contribute to better vaccination coverage; encompasses strong public health services; supports appropriate technologies that are affordable and have wide benefits; and encourages intersectoral actions (eg, with infrastructure) to ensure supply chains and provision of medicines.
3.c Substantially increase health financing and the recruitment, development, training, and retention of the health workforce in developing countries	Acts as the site for training and continuing professional development of all primary care professionals; and can be a positive working environment, which provides job satisfaction and encourages retention.	Promotes health financing and policies for worker retention.
3.d Strengthen the capacity for early warning, risk reduction, and management of national and global health risks	Identifies conditions early and participates in disease notification systems.	Promotes intersectoral approaches, including with public health, transport, agriculture, judiciary, and education.

Contribution  High contribution  Some contribution  Minor contribution  No contribution

Figure 1: Contribution of primary health care to the achievement of Sustainable Development Goal 3 (good health and wellbeing) SDG=Sustainable Development Goal. PHC=primary health care. UHC=universal health coverage.

	Reorienting health systems to primary care	Strengthening comprehensive PHC approaches
1 No poverty	Facilitates access to basic health-care services; alleviates health needs that contribute to poverty; addresses early-life determinants of poverty (eg, malnutrition, maternal health); provides lower cost health care, reducing impoverishment through lower or negligible out-of-pocket expenditures; and acts as a gateway to other social protection programmes.	Addresses health determinants that are congruent with determinants of poverty; promotes equity-enhancing and pro-poor policies; and promotes rights and community ownership of sources of income and employment.
2 Zero hunger	Identifies individuals at risk; delivers nutrition interventions and education; and carries out growth monitoring and health promotion.	Contributes to sustainable food systems through Health in All Policies approaches that include sustainable practices and more equitable distribution of production and consumption.
4 Quality education	Delivers health education to patients and communities; provides employment, training and continuing professional development opportunities to staff; addresses health concerns affecting participation in education (eg, sickness from school); and promotes access to education and some health services within schools.	Addresses education as a wider social determinant of health; ameliorates some causes of low educational attainment through public health actions, such as sanitation and infectious disease control; and promotes equity-enhancing health policies, which concur with equitable approaches to education.
5 Gender equality	Provides access to sexual and reproductive health care; acts as a gateway for access to gender-equity enhancing social protection programmes; addresses health needs contributing to gender inequality; and (should) offer equitable employment opportunities.	Promotes equity, including gender equity, as a fundamental principle; addresses gender inequalities, a social determinant of health; advocates for social justice including gender and reproductive rights; and develops women's full and effective participation through community empowerment and facilitating individual self-reliance.
6 Clean water and sanitation	Can help identify instances of water-borne pathogens and other risks; provides health education, and promotes basic hygiene (eg, hand-washing).	Encompasses public health actions, sanitation, and safe water as environmental determinants of health; and promotes community empowerment in these sectors for sustainability and effectiveness of interventions.
7 Affordable and clean energy	As a large consumer of energy, PHC can influence energy markets by purchasing from renewable sources; offers less energy-intensive health services than hospitals; and (can) promote the use of renewable energy sources for health-care-related transport systems.	Advocates clean energy production, household fuels and transport systems to address air and water pollution, as environmental determinants of health; encourages healthier transport (eg, active transport); and promotes universal access to energy as a health determinant.
8 Decent work and economic growth	Improves health as a foundation for employment and economic opportunities; provides employment; identifies and documents instances of injuries and deaths caused by unsafe working conditions; and facilitates monitoring of vulnerable individuals who might be victims of child or forced labour.	Addresses health determinants that are congruent with the basis of full and productive work; and encompasses equitable approaches facilitating inclusive growth and making technology universally accessible.
9 Industry, innovation, and infrastructure	Develops new health-care and health information technologies and applications, and is the main delivery channel for pharmaceutical and other biomedical industries (with both positive and negative effects).	Pro-equity policies promote inclusive approaches to new technologies; and reviews cost-effectiveness of health-related technologies and treatments, including identification and communication of potential harms and benefits.
10 Reduced inequalities	Reduces inequalities, particularly health-related, by facilitating access to health care and social welfare programmes; and has an important role in addressing early life determinants of health inequalities.	Acknowledges health inequalities as politically, socially, and economically unacceptable; advocates equity, social justice, and individual rights; and promotes empowerment through equity-enhancing policies.
11 Sustainable cities and communities	Reduces travel distances to health services by being community-based and accessible, and can be a focus for improving services and infrastructure in cities.	Stimulates action in sectors such as housing, transport, green-spaces, urban environment, public services, and urban planning to address social and environmental determinants of health; and facilitates participatory approaches to decision making for health, which can spread to other sectors.
12 Responsible consumption and production	<b>Addresses biomedical waste, including proper disposal of antimicrobial agents.</b>	Addresses pollution as an environmental health determinant; and there are policy synergies from PHC's focus on sustainable and healthy consumption.
13 Climate action	Offers more eco-friendly options than intensive, hospital-based, care; and contributes to strengthening resilience to climate-related hazards.	Provides policy synergies from healthy policies, promoting safe water, clean energy production, and sustainable cities; and fosters government and societal capacity for integrating policies to tackle climate change.
14 Life below water		Provides policy synergies from addressing water pollution; and recognises that sustainable and healthy water ecosystems are important for health.
15 Life on land		Provides policy synergies from addressing pollution, and promoting health and sustainable actions, in sectors such as agriculture, animal husbandry, food, safe water, and sanitation; and recognises importance of biodiversity and healthy ecosystems for human health.
16 Peace, justice, and strong institutions	Potentially acts as a gateway for accessing judicial and social protection systems; can be a setting for monitoring vulnerable individuals; and can assist in documenting violence, conflict, and human rights abuse, through Electronic Health Records and expert testimony.	Promotes equity and social justice as key principles; advocates for community empowerment; and emphasises that effective, accountable, and transparent institutions, and responsive, inclusive, participatory, and representative decision making, are requisites for PHC.
17 Partnerships for the goals	The global agenda for promoting primary care can be a focal point for international cooperation, capacity building, and policy coherence.	Fosters better approaches to systemic issues through community-engagement and policy coherence; promotes healthy public, public-private and civil society partnerships; and advocates for intersectoral partnerships that might be leveraged for greater donor coordination and effectiveness.

**Contribution** ■ High contribution ■ Some contribution ■ Minor contribution ■ No contribution

**Figure 2: The contribution of primary health care to the achievement of the Sustainable Development Goals (except goal 3)**  
PHC=primary health care.

PHC's actions on environmental determinants of health can also contribute to the SDGs by promoting clean, safe, and climate-friendly environments. Public health approaches and intersectoral action can improve access to clean water and sanitation (responsible for approximately 842 000 deaths in low-income and middle-income countries [LMICS])<sup>128</sup> and contribute to monitoring and promoting cleaner energy production (SDG 6 and SDG 7).<sup>129–133</sup> Health challenges in urban environments (SDG 11), such as air pollution, low physical activity, malnutrition, and inadequate sanitation,<sup>134</sup> can be improved through PHC's emphasis on sustainable and healthy approaches in urban sectors. These approaches include housing regulations and regeneration to improve heating, electricity, sanitation, and security; investing in public transport, redesigning road systems to reduce accidents, and reducing polluting vehicle usage; facilitating active transport; and promoting green space to reduce exposure to pollution, increase physical activity, and improve mental health.<sup>134,135</sup> PHC also offers contributions to environment-focused SDGs (12–15) through actions on environmental determinants of health, such as reducing pollution and hazardous chemicals, promoting clean energy production, fostering healthy food production, and recognising the importance of healthy ecosystems and the environment for human health.

Inequalities are a cross-cutting theme to many SDGs. The Alma-Ata declaration acknowledges health inequalities as “politically, socially and economically unacceptable”.<sup>2</sup> PHC's commitment to equity is strongly linked to actions on the wider determinants of health since it targets the poor and most vulnerable. Thus, actions to achieve PHC and SDG 10 are largely indistinguishable. PHC also aims to address discrimination against women because women's health is negatively affected by lower societal investment and not having the right to good health.<sup>67</sup> Beyond the broader health determinants, PHC's promotion of social justice, equity-enhancing policies, and the empowerment of communities and individuals are vital to directing action towards the poor and vulnerable. Broader movements of social justice and equity are important for embedding actions, such as rights-based approaches to health. They can draw attention to governments' responsibilities for health and promote access for disadvantaged populations, but inequalities, conflict, and inappropriate allocation of resources can occur, if not strategically implemented with a broader equity approach.<sup>136,137</sup> Furthermore, equity and social justice contribute to SDG 16 (peace, justice, and strong institutions)—a cross-cutting SDG underpinning nearly all other SDGs.

The Alma-Ata declaration states that PHC “requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care”.<sup>2</sup> In the SDG era, there is a focus on sustainability,<sup>138</sup> with community mobilisation and empowerment increasingly

recognised as important facilitators. Evidence highlights that community empowerment and participation are essential for acceptability, sustainability, long-term effectiveness, and uptake of health interventions.<sup>127,139–142</sup> Health facility committees offer one potential way of promoting quality and coverage of primary care,<sup>143</sup> and community participation is important for the success of local government initiatives for intersectoral action.<sup>60</sup> Although community participation approaches will also be essential for sustainability of other actions towards the SDGs, promoting participation in decision making for health is likely to translate into policy coherence, stronger accountability mechanisms, and valuable public, public–private, and civil society partnerships (SDG 17, partnerships for the goals).

### Promising opportunities and challenges for PHC in the SDG era

The absence of PHC in the SDG documents and policies remains a crucial oversight. The evidence base for PHC's potential contribution to many of the SDGs is stronger than ever. Countries with prioritised investments in primary care are better placed to achieve the SDGs than those with hospital-focused systems or limited investments in health. Those countries adopting a broad PHC approach can deliver substantially more—namely through actions to address the wider determinants of health, promoting equity and social justice throughout society, empowering communities, and capitalising on synergistic actions.<sup>86</sup> A wider PHC approach additionally serves as an important catalyst for advancing and amplifying UHC beyond a focus on the provision of curative health services. However, PHC is not a panacea for all problems in the world—in fact, this misinterpretation of Alma-Ata contributed to its poor uptake. It is not the role of health services (primary care) to deliver all these actions. PHC is a societal vision that provides a platform for all sectors to engage in. Importantly, the global consensus on the SDGs and commitments from governments, international organisations, and civil society to achieve them, provides an unprecedented opportunity to promote PHC. Global actions around financing, measuring, and institutionalising approaches to reach SDG targets are, perhaps for the first time, an opportunity to fully realise PHC's great promise.

Considerable barriers to implementing pro-PHC and pro-SDG policies remain in many countries. Political commitment is still weak in several key areas. Government commitment to health is vital for stronger primary care,<sup>13</sup> intersectoral action, and Health in All Policies approaches.<sup>60,61,144</sup> Health goals and priorities should be integrated into non-health sectors' strategies by demonstrating common objectives and synergies.<sup>61,144</sup> Social justice and equity also remain under-prioritised in many locations, and as evidenced by policies following economic recessions, policy makers have not only eroded many previous gains, but also damaged the public's trust

in such institutions.<sup>80,145</sup> Without a clear pro-equity focus, including gender equity, inequalities can widen because disadvantaged populations are likely to benefit less from new interventions or expanding coverage than are higher-income populations.<sup>51,75,146,147</sup> Policy makers should be reminded of the intrinsic value of health and equity, by embedding these basic human rights in constitutions and implementing legislation.<sup>144</sup> The technical and administrative capacity for delivering necessary changes and sustaining PHC approaches also needs to be strengthened, given they are crucial for institutionalising PHC approaches.<sup>144,148,149</sup> The complexity of PHC and interconnected systems must be recognised,<sup>22,149</sup> and understanding of the structural and systematic challenges that limit progress in local contexts needs to be improved.<sup>150</sup>

Th evidence to inform optimal PHC approaches to achieve SDG goals in different contexts, including financing, is limited. However, progressive, public, taxation-based financing is vital to build robust PHC systems.<sup>151–153</sup> Regressive consumption-based taxation runs contrary to PHC, especially when healthy foods, transport, and environmental services are taxed.<sup>152</sup> Many countries need to implement health budget reforms and introduce strategic purchasing arrangements to align resources with priorities, and increase flexibility, responsiveness, and accountability.<sup>153</sup> Opportunities for context-appropriate funding mechanisms also exist, such as shared funds for joint intersectoral activities,<sup>60</sup> participatory budgeting for local issues, and tailoring incentivisation mechanisms.<sup>149</sup>

PHC can only fulfil its potential to advance the SDG agenda with strong, sustained support from politicians, civil society, the public, and all other related sectors. Building trust in public institutions, transparent policy making, and redistributive efforts of governments are important for fostering social capacity, mobilising civil society, and effective bottom-up approaches.<sup>146</sup> Policy makers should plan mechanisms to involve communities in a more meaningful and substantial way in policies and interventions, and communities should take up these roles and challenge politicians to initiate and maintain their engagement. To help foster uptake, further understanding, research, and debate on PHC are urgently needed. It has become evident that intersectoral action on the broader determinants of health is essential, and a better understanding of how to improve these determinants is needed. Particularly, there is a need to understand the different forms PHC has taken at country level, identify facilitators and barriers to PHC adoption and sustainability, and evaluate its effect on both health and non-health-related outcomes.

## Conclusions

The SDGs provide a unique opportunity to make the case for renewed attention and investment in PHC as envisaged in the Alma-Ata declaration. As the global community considers its future direction for the coming

decades, Alma-Ata's 40th anniversary is the time to reaffirm commitments to PHC and recognise its importance across societies. The Alma-Ata declaration stated that PHC “reflects and evolves”,<sup>2</sup> hence its vision is relevant today and has great potential to contribute to the SDGs and other global initiatives, to foster more sustainable and equitable human progress.

### Contributors

CM conceived the idea of the Review, which was developed further with input from JM and TH. TH did the initial literature search with input from JM and CM. TH wrote the first draft of the manuscript, and all authors contributed equally to further drafts and revisions.

### Declaration of interests

JM has participated in expert consultations at WHO regarding the new Alma-Ata declaration. TH and CM declare no competing interests.

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