Primary health care and the Sustainable Development Goals

After the eight Millennium Development Goals that have shaped progress in the past 15 years, 17 Sustainable Development Goals (SDGs) were adopted by governments at the UN General Assembly in September, 2015. SDG3 explicitly relates to health—to “Ensure healthy lives and promote well-being for all at all ages”. This goal is translated into 13 targets: three relate to reproductive and child health; three to communicable diseases, non-communicable diseases, and addiction; two to environmental health; and one to achieving universal health coverage (UHC). Four further targets relate to tobacco control, vaccines and medicines, health financing and workforce, and global health risk preparedness.

When supported by strong public health policies and with aligned efforts across social, economic, and political domains, primary health care has a central role in achievement of sustainable development. Although differences are inevitable between countries in the organisation of primary health care and the human resources available, many of the challenges outlined in SDG3—related to reproductive and child health, communicable diseases, chronic illnesses (including multimorbidity), addiction, and other mental health problems—can be addressed through a person-centred and population-based approach to primary health care.1–5 Delivery of vaccines and drugs needs a functioning primary care system. Well integrated and prepared primary health care has a key role in health emergency responsiveness, and it is essential for the achievement of UHC equitably and cost-effectively.6–8

Moreover, primary health care can contribute to the achievement of many of the 16 other SDGs; for example, its role in addressing the social determinants of health was underlined in the report Closing the Gap in a Generation. Primary care teams worldwide can provide examples from daily practice that illustrate their contribution across the SDGs, including helping to end poverty, improve nutrition, provide health education and promote lifelong learning, empower individuals and communities to reduce inequities and promote justice, enable access to safe water and sanitation, encourage productive and sustainable employment, foster innovation, advocate for healthy and sustainable living environments, and promote peaceful communities.

Yet investment in realising the full potential of primary health care still seems elusive to many governments, policy makers, funders, and health-care providers. Therefore, 7 years after the World Health Report and The Lancet Series on primary health care, and 37 years since the Alma-Ata declaration, the absence of reference to primary health care in the SDGs and their targets seems a serious oversight. Two conclusions could be drawn: first, that primary health care is dispensable and peripheral to achieving sustainable development; or, second, that primary health care is so integral to the path towards the SDGs that reference in a goal or target would undermine its cross-cutting role.

We opt for the second conclusion, yet do so with apprehension, because one of the contributing factors to the documented failure of primary health care in many settings since the Alma-Ata declaration was “the scarcity of a proposed strategy for implementation and its monitoring for accountability and scale-up purposes”.9 This issue needs to be addressed in the development of implementation strategies for the SDGs. If the agenda is not explicit about how health systems with good-quality comprehensive primary care can be achieved, or how to measure progress towards this goal, we risk repeating the failures of the past.

National governments and other stakeholders need to be ambitious in measuring progress towards delivery of primary health care that will address the SDGs. This monitoring includes the use of indicators that can capture

For Sustainable Development Goals (SDGs) see https://sustainabledevelopment.un.org/topics
For the report Closing the Gap in a Generation see http://www.who.int/social_determinants/thecommission/finalreport/en/
the principles of equity, community participation, prevention, appropriate technology, and inter-sectoral collaboration underpinning the Alma-Ata declaration, and which can also document the elements of first contact, continuity, comprehensiveness, coordination, and family and community orientation which, evidence suggests, make primary care services successful.10 Health financing indicators need to track government expenditure in this area and provide information on the economic accessibility of primary care services.

At the interface between the community, the health system, and other sectors, the primary care workforce is arguably the backbone of the entire health system. The density, distribution, and performance of this workforce, which includes community health workers, nurses, midwives, family doctors, and allied health professionals, should be monitored.11 Meanwhile, addressing the underfunding of the research agenda for primary health care within health systems research will help us to understand how to best scale-up the primary care workforce, taking available national resources into account, as well as how to halt and reverse the brain drain of health professionals.12,13

Countries need strong political will, sound economic policies, and coordinated international efforts to achieve UHC. Measuring progress towards the implementation of primary health care is no easy task, yet it is the lynchpin of achieving UHC. Measuring progress towards the implementation of primary health care within health systems research will help us to understand how to best scale-up the primary care workforce, taking available national resources into account, as well as how to halt and reverse the brain drain of health professionals.12,13

As the UN Inter-agency and Expert Group continues to deliberate on the SDG indicators, the Gates Foundation, World Bank Group, and WHO have stepped into the spotlight with the launch of the Primary Health Care Performance Initiative. This initiative, alongside the forthcoming WHO People-Centred and Integrated Health Services Strategy and the Global Strategy on Human Resource for Health: Workforce 2030, will be important in shaping how primary health care develops in the next 15 years and in steering the associated research agenda. These initiatives should encourage governments to invest in and measure progress towards good-quality, comprehensive and integrated primary health care that is based on sound evidence. The risk at this juncture of not doing so is that the pursuit of vertical disease-oriented programmes will prevail.19 Such a pursuit will be at the cost of equitable UHC and the realisation of the full potential of primary health care’s contribution to sustainable development.

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A transition towards a healthier global population?

The latest estimates from the Global Burden of Disease (GBD) team explicitly address not only increases in life expectancy, but also the extent to which additional years of life are associated with good health and the implications for the process of epidemiological transition around the world. In the period 1990–2013, they report that worldwide life expectancy at birth increased by 6.2 years (95% uncertainty interval 5.6–6.6), and healthy life expectancy at birth by 5.4 years (4.9–5.8). Although the study notes a widespread shortage of relevant data about disability, evidence such as there is suggests that years of life are associated with good health and healthy life expectancy gained are not necessarily lived healthily.

The figure, created with data from the appendix to the GBD study, shows healthy and unhealthy life expectancy for the 21 GBD world regions in 2013. A fairly consistent pattern emerges: about an eighth of life expectancy (dark bars) with 95% UI, by GBD world regions

This idea of a grand convergence is related to the concept of the epidemiological transition, first proposed by Abdel Omran in 1971, but which was neither entirely evidence-based nor defined in terms of specific outcomes. In general terms, Omran conceptualised that causes of death in populations would move away from infectious causes of disease towards non-communicable causes as time passed, and health improved. The GBD team has coined their own concept of a sociodemographic status index to track the epidemiological transition, based on important parameters that were available for all countries during the 1990–2013 time period. The sociodemographic

![Figure: Healthy life expectancy (light bars) with 95% UI and total life expectancy (dark bars) with 95% UI, by GBD world regions](image-url)

Visible parts of dark bars represent the proportion of total life expectancy associated with disability. Data about life expectancy and healthy life expectancy (with 95% UIs) for each GBD region in 2013 taken from GBD appendix (pp 1159–62). UI=uncertainty interval. GBD=Global Burden of Disease.