Report of the Global Conference on Primary Health Care:
From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals
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The views expressed in this document do not necessarily represent the opinions of the individuals mentioned here or their affiliated institutions.
Executive summary

On 25 and 26 October 2018, government ministries, United Nations organizations, nongovernmental organizations, and civil society came together in Astana, Kazakhstan, for the Global Conference on Primary Health Care: From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals. The Conference celebrated the 40th anniversary of the first International Conference on Primary Health Care, held in 1978 in Almaty (then called Alma-Ata), Kazakhstan. The Conference was co-hosted by the Government of Kazakhstan, the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO).

The 1978 Declaration of Alma-Ata founded the movement for primary health care. It called for health for all, and was the first declaration of health as a fundamental human right. The Declaration of Alma-Ata was the first document to set out a holistic view of health and put an emphasis on the contribution of health to economic and individual development.

There have been many improvements in the decades since Alma-Ata, most notably in child and maternal mortality and in longevity, but a number of challenges remain. The final report of the WHO Commission on Social Determinants of Health is one of many reports that have demonstrated the wide inequalities in health outcomes between and within countries. The world has achieved health for some, but not yet health for all.

The Astana Conference built on the foundation of Alma-Ata by bringing stakeholders together to endorse a new declaration attuned to the challenges of the 21st century, and to rethink the principles of Alma-Ata with a deeper understanding of their practical implications in today's world.

The Declaration of Astana was passed on the first day of the Conference, highlighting the essential role of primary health care in promoting good health, social and economic development, and global security. The Declaration of Astana reaffirms the central tenet of the Declaration of Alma-Ata: that health is a right, not a privilege for those who can afford it.
By endorsing the declaration, participants affirmed their commitment to promoting primary health care as a means of achieving universal health coverage and the 2030 Agenda for Sustainable Development.

Participants acknowledged that primary health care is a driver, not just an outcome, of sustainable development, and as such, primary health care is a smart investment. Better health means higher productivity. In order to convey the economic case for investment in primary health care effectively, health ministers and their counterparts in ministries of finance must find a simple common language. It is essential that health ministers are able to present a concise and compelling argument that clearly sets out the positive returns on investment that primary health care promises. Technical agencies and development partners can play a key supportive role in helping health ministers achieve this.

Innovations in the way health is financed can also help incentivize health promotion and disease prevention, in order to rebalance systems that are currently too focused on curative interventions. Such innovative financing can also smooth the transition from a vertical approach centred on specific diseases, to an integrated, holistic approach to health systems.

Participants affirmed that no single issue could be at the centre of the drive to universal health coverage or the primary health care agenda. Ensuring populations receive the right care, at the right time, in the right place, in accordance with their needs and local contexts, requires effective integration of providers and care settings based on a strong primary health care system. This includes integrating public health in primary health care, as well as breaking down the silos between primary care and hospital care.

Delivering this integrated care will require a primary health care workforce fit for the 21st century. Investment must encompass the empowerment of individuals and communities, with recognition of the importance of skills, local context and health needs. Health care workers should be empowered through policies that promote their well-being, and ensure they are engaged in decisions about their working environment.
Strong, integrated health systems based in primary health care also function as the first line of defence in emergencies, whether in acute or protracted crises. A strong health system is a resilient health system. Conversely, poor-quality primary health care can contribute to the escalation of emergencies through poor standards of infection prevention and control, a lack of appropriate equipment, and untrained staff.

Addressing the determinants of health will be key to improving outcomes. Participants affirmed that societies have a moral obligation to help their most vulnerable citizens. It is crucial to identify exactly where inequities in access and outcome lie; new technology can play an important role here. The revolution in connectivity has the potential not only to broaden access to primary health care and training, but also to help identify areas where access is lacking. Examples from all WHO regions show that expanding access and tackling inequities is possible even in the face of limited financial resources, as long as the political will is present.

Equity is at the heart of people-centred primary health care. Primary health care is key to achieving equitable sexual, reproductive, maternal, newborn, child and adolescent health care. The world’s population is also rapidly ageing, and health systems will need to adapt to respond to the growing health and social care needs of older people.

The Conference took place after a one-day Youth Preparatory Workshop with young health professionals, where participants acknowledged that young people are ready and willing to take responsibility and leadership. This generation of young people is the most connected in history and has unprecedented voice and power. Young people are the key to implementing the Declaration of Astana. They want to contribute and be held accountable.

Realizing the aims of the Declaration of Astana will require coordinated, collective international action. Speakers urged participants to ensure that Astana was the moment the world comes together to ensure that the right to health becomes a reality in the 21st century. Primary health care must be seen as a launching pad for people, nations, and communities to thrive; as an investment, not a cost; and as a movement, not a moment.
Day 1: key messages

Plenary sessions

- The Declaration of Alma-Ata was the first document to set out a holistic and comprehensive view of health and well-being, and the first declaration to recognize health as a fundamental human right. It brought together countries in one unified health movement for the first time.

- Over the past four decades, countries have made significant progress in primary health care, though progress has been uneven, with wide disparities in health outcomes both within and between countries.

- Primary health care remains a driver, not just an outcome, of sustainable development. Its principles are at the very core of achieving universal health coverage, the Sustainable Development Goals, and the “triple billion” goals set out in the WHO 13th General Programme of Work.

- Recognizing that today the world is a different place than it was in 1978, and that we now have a deeper, more comprehensive understanding of the practical implications in today’s world of the original principles of solidarity, equity, and justice laid out in the Declaration of Alma-Ata, the Declaration of Astana was adopted by government representatives.

- Young people and young health professionals have a critical role to play in carrying forward the foundation set by the Declaration of Astana and realizing primary health care goals in the 21st century.

- New technologies have the potential to transform primary health care, especially by introducing new levels of connectivity.

Parallel sessions

- The success of primary health care depends on collective and aligned action by diverse global, regional, national, and subnational stakeholders.

- The time is now to invest in building and training a sustainable and multidisciplinary primary health care team.

- Ensuring populations receive the right care, at the right time, in the right place, in accordance with their needs and local contexts, requires effective integration of providers and care settings based on a strong primary health care system. This includes integrating public health in primary health care, as well as breaking the silos between primary care and hospital care.

- Private sector actors are extremely diverse and wide-ranging and can contribute positively to improving primary health care.
Day 2: key messages

Plenary sessions

• Primary health care is a smart investment with both macro- and microeconomic benefits.

• Country examples from all regions show that expanding access and reversing inequities is possible even in the face of limited financial resources, as long as political will is present.

• No single issue lies at the centre of primary health care or universal health coverage – the primary health care agenda moves beyond vertical approaches and requires high-level commitment to action beyond the health sector.

• Primary health care is a strategy for health and well-being centred on individuals, families and communities. It must no longer be considered as the provision of a limited package of care for the poor. It calls for improved and equitable access to quality services and addresses the social determinants of health. Governments must now honour the rights of their people and assume accountable leadership to build resilient and equitable health systems based in primary health care.

• In closing the day, heads of international organizations and United Nations agencies implored participants to take full advantage of the discussions and commitments made in Astana and urged the world to come together to drive primary health care progress and ensure that the right to health becomes a reality in the 21st century.

Parallel sessions

• It is not sufficient to provide access to services; services must also be of good quality.

• Primary health care is the first line of defence in emergencies, but poor-quality primary health care can contribute to the escalation of emergencies.

• High-level commitment is essential to ensure that appropriate intersectoral structures are in place to enable collaboration and avoid overburdening existing staff.

• People, including young people and communities, must be empowered and active participants in developing services tailored to their specific needs rather than just being recipients of care.

• Until now we have followed a false dichotomy between noncommunicable diseases and communicable diseases – our focus must simply be on people. Primary health care provides the lens for this focus.
Declaration of Astana

We, Heads of State and Government, ministers and representatives of States and Governments, participating in the Global Conference on Primary Health Care: From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals, meeting in Astana on 25 and 26 October 2018, reaffirming the commitments expressed in the ambitious and visionary Declaration of Alma-Ata of 1978 and the 2030 Agenda for Sustainable Development, in pursuit of Health for All, hereby make the following Declaration.

We envision

Governments and societies that prioritize, promote and protect people’s health and well-being, at both population and individual levels, through strong health systems;

Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;

Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;

Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.
We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. Convening on the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, in particular to justice and solidarity, and we underline the importance of health for peace, security and socioeconomic development, and their interdependence.

We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people’s physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals. We welcome the convening in 2019 of the United Nations General Assembly high-level meeting on UHC, to which this Declaration will contribute. We each pursue our paths to achieving UHC so that all people have equitable access to the quality and effective health care they need, ensuring that the use of these services does not expose them to financial hardship.

We acknowledge that in spite of remarkable progress over the last 40 years, people in all parts of the world still have unaddressed health needs. Remaining healthy is challenging for many people, particularly the poor and people in vulnerable situations. We find it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist.

We will continue to address the growing burden of noncommunicable diseases, which lead to poor health and premature deaths due to tobacco use, the harmful use of alcohol, unhealthy lifestyles and behaviours, and insufficient physical activity and unhealthy diets. Unless we act immediately, we will continue to lose lives prematurely because of wars, violence, epidemics, natural disasters, the health impacts of climate change and extreme weather events and other environmental factors. We must not lose opportunities to halt disease outbreaks and global health threats such as antimicrobial resistance that spread beyond countries’ boundaries.

Promotive, preventive, curative, rehabilitative services and palliative care must be accessible to all. We must save millions of people from poverty, particularly extreme poverty, caused by disproportionate out-of-pocket spending on health. We can no longer underemphasize the crucial importance of health promotion and disease prevention, nor tolerate fragmented, unsafe or poor-quality care. We must address the shortage and uneven distribution of health workers. We must act on the growing costs of health care and medicines and vaccines. We cannot afford waste in health care spending due to inefficiency.
We commit to:

**IV**

**Make bold political choices for health across all sectors**

We reaffirm the primary role and responsibility of Governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health. We will promote multisectoral action and UHC, engaging relevant stakeholders and empowering local communities to strengthen PHC. We will address economic, social and environmental determinants of health and aim to reduce risk factors by mainstreaming a Health in All Policies approach. We will involve more stakeholders in the achievement of Health for All, leaving no one behind, while addressing and managing conflicts of interest, promoting transparency and implementing participatory governance. We will strive to avoid or mitigate conflicts that undermine health systems and roll back health gains. We must use coherent and inclusive approaches to expand PHC as a pillar of UHC in emergencies, ensuring the continuum of care and the provision of essential health services in line with humanitarian principles. We will appropriately provide and allocate human and other resources to strengthen PHC. We applaud the leadership and example of Governments who have demonstrated strong support for PHC.
Build sustainable primary health care

PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions. We will prioritize disease prevention and health promotion and will aim to meet all people’s health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care. PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of noncommunicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health. PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive. We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. We will benefit from sustainable PHC that enhances health systems’ resilience to prevent, detect and respond to infectious diseases and outbreaks.

The success of primary health care will be driven by:

Knowledge and capacity-building. We will apply knowledge, including scientific as well as traditional knowledge, to strengthen PHC, improve health outcomes and ensure access for all people to the right care at the right time and at the most appropriate level of care, respecting their rights, needs, dignity and autonomy. We will continue to research and share knowledge and experience, build capacity and improve the delivery of health services and care.

Human resources for health. We will create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people’s health needs in a multidisciplinary context. We will continue to invest in the education, training, recruitment, development, motivation and retention of the PHC workforce, with an appropriate skill mix. We will strive for the retention and availability of the PHC workforce in rural, remote and less developed areas. We assert that the international migration of health personnel should not undermine countries’, particularly developing countries’, ability to meet the health needs of their populations.

Technology. We support broadening and extending access to a range of health care services through the use of high-quality, safe, effective and affordable medicines, including, as appropriate, traditional medicines, vaccines, diagnostics and other technologies. We will promote their accessibility and their rational and safe use and the protection of personal data. Through advances in information systems, we will be better able to collect appropriately disaggregated, high-quality data and to improve information continuity, disease surveillance, transparency, accountability and monitoring of health system performance. We will use a variety of technologies to improve access to health care, enrich health service delivery, improve the quality of service and patient safety, and increase the efficiency and coordination of care. Through digital and other technologies, we will enable individuals and communities to identify their health needs, participate in the planning and delivery of services and play an active role in maintaining their own health and well-being.

Financing. We call on all countries to continue to invest in PHC to improve health outcomes. We will address the inefficiencies and inequities that expose people to financial hardship resulting from their use of health services by ensuring better allocation of resources for health, adequate financing of primary health care and appropriate reimbursement systems in order to improve access and achieve better health outcomes. We will work towards the financial sustainability, efficiency and resilience of national health systems, appropriately allocating resources to PHC based on national context. We will leave no one behind, including those in fragile situations and conflict-affected areas, by providing access to quality PHC services across the continuum of care.

In joining consensus, the delegation of the United States of America wishes to draw attention to objective 8.25 of the Programme of Action of the Report of the International Conference on Population and Development, which states “in no case should abortion be promoted as a method of family planning”.

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VI

Empower individuals and communities

We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. We will promote health literacy and work to satisfy the expectations of individuals and communities for reliable information about health. We will support people in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care, guided by health professionals. We will protect and promote solidarity, ethics and human rights. We will increase community ownership and contribute to the accountability of the public and private sectors for more people to live healthier lives in enabling and health-conducive environments.

VII

Align stakeholder support to national policies, strategies and plans

We call on all stakeholders – health professionals, academia, patients, civil society, local and international partners, agencies and funds, the private sector, faith-based organizations and others – to align with national policies, strategies and plans across all sectors, including through people-centred, gender-sensitive approaches, and to take joint actions to build stronger and sustainable PHC towards achieving UHC. Stakeholder support can assist countries to direct sufficient human, technological, financial and information resources to PHC. In implementing this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices while fully respecting national sovereignty and human rights.

• We will act on this Declaration in solidarity and coordination between Governments, the World Health Organization, the United Nations Children’s Fund and all other stakeholders.

• All people, countries and organizations are encouraged to support this movement.

• Countries will periodically review the implementation of this Declaration, in cooperation with stakeholders.

• Together we can and will achieve health and well-being for all, leaving no one behind.
Background and objectives

On 25 and 26 October 2018, government ministers, United Nations organizations, nongovernmental organizations, civil society and young people came together in Astana, Kazakhstan, for the Global Conference on Primary Health Care: From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals. The Conference celebrated the 40th anniversary of the International Conference on Primary Health Care, held in 1978 in Almaty (then called Alma-Ata), Kazakhstan.

The Declaration of Alma-Ata in 1978 founded the movement for primary health care. It called for health for all and was the first declaration of health as a fundamental human right. The Astana Conference sought to build on this foundation by bringing stakeholders together to endorse a new declaration attuned to the challenges of the 21st century.

The Declaration of Astana highlights the essential role of primary health care in promoting good health, social and economic development, and global security. By endorsing the declaration, Conference participants affirmed their commitment to promoting primary health care as a means of achieving universal health coverage, Sustainable Development Goal (SDG) 3 on good health and well-being, and all the other SDGs for which health is a contributing factor.

In addition to the adoption of the Declaration of Astana, the Conference also afforded attendees the opportunity to participate in a range of plenary, parallel and focused discussion sessions to explore how best to strengthen primary health care in a variety of different contexts.

Conference organization

The Conference was co-hosted by the Government of Kazakhstan, the United Nations Children’s Fund (UNICEF) and the World Health Organization (WHO). More than 2 000 participants from nearly 150 WHO Member States attended, alongside representatives from United Nations technical agencies, nongovernmental organizations, civil society, and youth organizations, including at least 150 young people.

The main programme was organized across two days and comprised six plenary sessions and 19 ministerial parallel sessions divided into five thematic areas (Annex 1). The Declaration of Astana was officially adopted on the morning of the first day.

In addition to the main programme, numerous informal café sessions, side events and working groups met in the margins of the meeting.

The Government of Kazakhstan also hosted a varied programme of cultural and social events in Astana for the benefit of participants.
Opening and introductory remarks

The Conference was opened by Dr Hans Kluge, Director of Health Systems and Public Health, WHO Regional Office for Europe, as co-chair and on behalf of the Alma-Ata 40th Anniversary Coordination Team. Representatives from the three co-hosts then addressed the Conference.

Erbolat Dossaev, Deputy Prime Minister of Kazakhstan, welcomed participants to Astana, and highlighted the rapid progress that Kazakhstan had made in key health indicators since gaining independence. The country had a strong focus on primary health care, which was a core part of the President’s 40-year national development strategy, which was launched in 2012. He underlined his pride that Kazakhstan was the birthplace of the Declaration of Alma-Ata, and expressed hope that the Declaration of Astana, developed with the participation of more than 1 000 participants from around the world, would be the foundation for health systems globally in the 21st century.

Speaking on behalf of WHO, Zsuzsanna Jakab, Regional Director of the WHO Regional Office for Europe, noted that the 40th anniversary of the Declaration of Alma-Ata afforded a unique opportunity to reflect on its legacy. Alma-Ata connected health, well-being, quality of life, and world peace, and was the moment the global health movement was born. The principles of Alma-Ata were at the core of the SDGs and the WHO 13th General Programme of Work. Alma-Ata had thus achieved a status that was the ambition of every declaration. The purpose of the present Conference was to rethink the principles of Alma-Ata with a deeper understanding of their practical implications in today’s world. She expressed gratitude to the authors of the Declaration of Alma-Ata for their foresight and wisdom, and hoped that the Declaration of Astana would have such a lasting impact.

Speaking on behalf of UNICEF, Ted Chaiban, Director of Programmes of UNICEF, remarked that primary health care was the key that would unlock a healthier and more prosperous world for all. A new primary health care model for the 21st century must be owned by everyone, and delivered by all sectors with an influence on health outcomes. It must be rooted in communities, and it must focus on meeting the needs of people of all ages. Adolescent health and well-being in particular was an area that UNICEF would now address by expanding its remit to also encompass the second decade of life. The challenges were substantial, but the opportunities were greater. We could revitalize our approach to primary health care, and build a healthier world for everyone. Primary health care was the road to universal health coverage. He concluded by urging the Conference to ensure that primary health care be a movement, not just a moment.
Summary of plenary sessions

First plenary session: revitalizing primary health care for the 21st century to achieve universal health coverage

Moderators
James Chau, Broadcaster, Writer, WHO Goodwill Ambassador for Sustainable Development Goals and Health
Yelzhan Birtanov, Minister of Health Care, Kazakhstan

Chair
Veronika Skvortsova, Minister of Health, Russian Federation

The session was opened and chaired by Veronika Skvortsova, Minister of Health of the Russian Federation, who invited Rifat Atun, Professor of Global Health Systems at Harvard University and Director of the Global Health Systems Cluster at Harvard T.H. Chan School of Public Health, to give a short presentation looking back on the 40 years since the Declaration of Alma-Ata, and framing the context for the Declaration of Astana.

In his presentation, Professor Atun said that the Declaration of Alma-Ata was the first document to set out a holistic view of health and put an emphasis on the contribution of health to economic and individual development. More importantly, it was the first declaration to recognize health as a fundamental human right. In the intervening period, much had changed geopolitically. There had been improvements, most notably in child and maternal mortality and in longevity, but problems remained. As the WHO Commission on Social Determinants of Health had indicated, there were wide inequalities in health outcomes between and within countries. Many countries had followed the principles of the Declaration of Alma-Ata, and scaled up their primary health care to achieve universal health coverage. Countries in the European Region had led the way in universal health coverage, but many countries from other regions had also been able to achieve universal health coverage by investing in people, partnerships and platforms, and many had demonstrated the necessary political will. By looking at the countries that had successfully followed the principles of Alma-Ata, a number of key features for successful primary health care emerged:

- People-centred, taking into account the needs of the population;
- Integrated, not just in terms of services for different conditions, but across different levels within the health system and with other sectors such as social care;
- Coordinated care, within and across health care;
- Continuous care across the life-course;
- Comprehensive care, not just poor services for the poor;
- Participative, including civil society and all stakeholders;
- Accountable to users;
- Evidence-based;
- Technologically enabled.
Yelzhan Birtanov, Minister of Health Care of Kazakhstan, said his country placed emphasis on patient-centred primary health care, with patient organizations and nongovernmental organizations actively participating in service assessments and planning.

Bernard Haufiku, Minister of Health and Social Services, Namibia, noted that in Namibia the backbone of primary health care was the community health worker. They were affordable to train and trusted by the community, and they would be crucial for national delivery of primary health care and universal health coverage. There was a need for continuous, well-designed training in order to maintain and improve the quality of services available through community health workers.

Adolfo Rubinstein, Secretary of Health, Argentina, said that in most low- and middle-income countries, primary health care was fragmented into many vertical programmes, and Latin America was not immune to that fragmentation. Argentina’s health care system encountered the same problem, with negative impacts on quality. Universal health coverage was nominal and implicit rather than actual and explicit. A third of the country’s population of 45 million people did not have health insurance.

Seyed Hassan Ghazizadeh Hashemi, Minister of Health and Medical Education, Islamic Republic of Iran, noted that the country’s Parliament had approved the expansion of primary health care in 1984, leading to the training of a network of community health workers that formed the basis for establishing people-centred, integrated health services. In 2014, the country had launched a health transformation strategy for establishing universal health coverage and improving access to quality health services, with a special focus on poor and marginalized groups. Around 92% of the country’s population was currently covered by health insurance.

Nila Farid Moeloek, Minister of Health, Indonesia, noted that in Indonesia national health insurance covered 77% of the population, but plans were in place to increase that figure to 95% by 2019. Her country stood ready to champion a regional and global mechanism for the assessment of primary health care. Achieving universal health coverage would be the best way to ensure efficient primary health care in national health services.

Yana Panfilova of Ukraine, now 20 years old, recounted her experience as a child and adolescent of her country’s primary health system from a patient’s perspective. Yana
had been born with HIV, and had experienced numerous setbacks in the diagnosis and treatment of complications of her disease. One of the biggest challenges she had faced had been the lack of direct communication with doctors about her health, leaving her uninformed and unable to participate in making many important decisions about her health and her future. Realizing that many adolescent and young people were in similar situations, she had decided to act, and had set up a network to enable young people living with HIV and other chronic health conditions to talk with each other, access the information they needed and participate in their own care. It was critical to engage children, adolescents and young people – especially those with chronic conditions and disabilities – as partners in their own care, providing them with opportunities to be heard and to access universal, good-quality, integrated health care services.
High-level government plenary session: whole-of-government approach to advancing primary health care towards universal health coverage, and adoption of the Declaration of Astana

Moderator
Yelzhan Birtanov, Minister of Health Care, Kazakhstan

Key messages
• Primary health care is a driver, not just an outcome, of sustainable development.
• Progress since Alma-Ata has been uneven, with wide disparities in health outcomes both within and between countries.
• International collective action would be the key to realizing the aims of the Declaration of Astana.
• The Declaration of Astana was officially adopted.

The first plenary session continued with moderation provided by Yelzhan Birtanov, Minister of Health Care of Kazakhstan, who presented a televised statement from Nursultan Nazarbayev, President of Kazakhstan. President Nazarbayev hailed the contribution of the Declaration of Alma-Ata to health around the world, and stressed the importance of international cooperation to realize primary health care. Although new challenges had emerged, such as environmental degradation and an increasing burden of chronic diseases, the digital revolution offered potential new solutions. He concluded by thanking all attendees for their participation, and wished them a successful and fruitful Conference.

The Conference then viewed a televised address from António Guterres, Secretary-General of the United Nations. He noted that health was at the centre of our vision for a more equal and prosperous future; it was not only an outcome but also a driver of sustainable development. Everyone needed access to quality health care over their lifetime without being pushed into poverty. There was a need for greater focus on prevention, and a clear imperative to strengthen delivery of primary health care. In conclusion, he thanked participants for their commitment to the goals of primary health care and universal health coverage.

Bakhytzhan Sagintayev, Prime Minister of Kazakhstan, then addressed the Conference from the stage. He expressed his pride that, 40 years ago, the Declaration of Alma-Ata had been adopted in Kazakhstan. Since gaining independence in 1991, primary health care had been a major priority of the country's national health system. Throughout 27 years of independence, the country had established a comprehensive primary health care infrastructure through the opening of 1 800 primary care clinics, with a strong emphasis on prevention. The country now routinely immunized against 21 infectious diseases, with 5 million people vaccinated each year. Health was a fundamental priority, central to the country's development and modernization. Spending on health care and education would increase to 10% of GDP in 2019; all citizens would have a digital health passport; and 100 fitness and wellness facilities would be constructed to promote healthy lifestyles. The Declaration of Astana would set a new direction for primary health care as the basis of the health systems of all countries. He expressed his gratitude to all those who had contributed to the development of the document, and said that the Declaration of Astana must be promoted and put forward to the United Nations General Assembly. Nations must unite to promote primary health care in the 21st century.
The Conference then heard from a representative of the Holy See, who conveyed a message from Pope Francis, who sent his greetings to all gathered and prayed that, through their deliberations, participants may be strengthened in their efforts to raise awareness of and seek sustainable solutions to the systemic tendency towards growing inequalities in health care.

Speaking from the stage, Upendra Yadav, Deputy Prime Minister of Nepal, paid tribute to primary health care leaders and practitioners for their enormous contribution to spreading the principles of Alma-Ata. Nepal had made remarkable progress in terms of health indicators, made possible by the global push to primary health care. The Nepal Public Health Act of 2018 enshrined health as a public right, while a health insurance scheme had been launched to protect people from financial hardship. Finally, he emphasized his confidence that developed countries would work together and collaborate with the least developed countries to achieve universal health coverage.
Tedros Adhanom Ghebreyesus, WHO Director-General, began by paying tribute to one of his predecessors, Halfdan Mahler, who, as Director-General of WHO, had been one of the architects of the Declaration of Alma-Ata. Dr Ghebreyesus also recognized the presence of Toregeldy Sharmanov, former Minister of Health of Kazakhstan, another of the main architects of the Declaration of Alma-Ata. The Conference in Astana was in large part because of the vision of those giants, but we must acknowledge that we had not achieved that vision. We had health for some, but not for all. Progress had been uneven and unfair between and within countries, with a 31-year disparity between those countries with the shortest and longest life expectancy. At least half of the world’s population lacked access to basic services, while the cost of paying for care out of pocket pushed people into extreme poverty. Too great a focus had been placed on fighting individual diseases at the expense of strengthening health systems and promoting health. The Declaration of Astana committed its signatories to putting people at the centre, not diseases, and expressed commitment to taking action across sectors to address the social, economic and environmental determinants of health, and to building the services that meet people’s needs throughout their lives. Health was a human right, not a privilege for those who could afford it. The world had changed in many ways since 1978, but the right to health had not changed. Whether or not to invest in health was a political choice, but health was not a political toy. The question was, could we succeed where we had failed before? The present Conference was our second chance to achieve health for all. In 2019, the High-Level Meeting on Universal Health Coverage presented a unique opportunity to rally world leaders in support of health for all. In conclusion, he urged attendees to use their influence to ensure that their Heads of State and Government attended the High-Level Meeting.
Henrietta Fore, Executive Director of UNICEF, noted that, compared with 40 years ago, by every measure the world was a healthier place. But as we make progress, as a global community we must face the difficult fact that for hundreds of millions of people the promise of Alma-Ata remained unfulfilled. Our task was to find together new ways to reach the people who were still left behind. The deaths of more than 4 million women and children each year could be averted by investing more in primary health care. In addition, bringing services and robust health systems to those who needed them provided an excellent return on investment. That was why UNICEF was working with governments and civil society to build those systems. It also meant finding new approaches to funding front-line health workers. There was a need to strengthen collaboration with partners at the country level to reduce fragmentation; to seek new opportunities with the private sector to deliver services more effectively; and to work together to manage supply chains, equip facilities and train staff. Moving forward, it was necessary to recall another unfulfilled promise: participation. The success of primary health care depended on the participation of individuals, families, communities and young people. In the months preceding the Conference, UNICEF had used its U-Report platform to poll almost 385 000 young people from 25 countries, the biggest poll of its kind. There was a clear message that young people cared deeply about primary health care. The survey found that 97% of young people took action to keep themselves healthy and promote health, and that 40% prioritized quality first, but almost half (46%) saw hospitals as the first place to go due to lack of access to primary health care, while 20% self-medicated and 32% avoided treatment because of fear.
Vytenis Andriukaitis, European Commissioner for Health and Food Safety, recalled the passage of the Declaration of Alma-Ata during his time as a medical doctor in Lithuania. These were critical times for global health – the only way to reach the goals of primary health care and universal health coverage was through prioritization of health in national budgets worldwide. The European Union had played an important role in shaping the 2030 Agenda for Sustainable Development, reflecting its longer-term agenda. There was a need for international collective action, supported by global regulatory frameworks. The European Commission was working with Member States to develop best practices. The political will to meet the 2030 Agenda existed, and the present Conference was another signal that health was being given high priority. It was important to make the most of that momentum and ensure that all the political goodwill was translated into concrete policies. We could no longer point to a lack of evidence of the links between health and wealth. We needed comprehensive action plans to enable us to deliver on the ground – 9 billion people deserved more action.

Githinji Gitahi, Group Chief Executive Officer of Amref Health Africa and Co-Chair of the UHC2030 Steering Committee, said that there were many signs that change was coming. Civil society organizations were increasingly being recognized in the movement towards primary health care. However, 40 years after Alma-Ata, there was still an inequitable health system. What had gone wrong? One reason was that the health care system was still characterized by vested interests, asymmetry of information, and politicians keener on ribbon-cutting and other manifestations of visible health care rather than actual health care. On the other hand, the primary health workforce, including community health workers, were given much less prominence in the media. The 2017 Global Monitoring Report on tracking universal health coverage used physicians, psychiatrists and surgeons as proxy indicators of service capacity and access, rather than more apposite indicators such as nurses, community health workers and midwives.

Leao Talalelei Tuitama, Minister of Health of Samoa, observed that change was possible, and that strong political will was necessary to achieve that change. In Fiji, in 1995, Heads of State committed the Pacific Islands to the Healthy Islands vision, which endorsed healthy islands as places where children were nurtured in body and mind; people worked and aged with dignity; ecological balance was a source of pride; and the ocean was protected. That vision had been built directly on the Declaration of Alma-Ata, with strong links to the notion of health services for all. He concluded by reminding the Conference that only a collective response to the challenges of our time could succeed. Unity and solidarity were key principles in ensuring that primary health care was the foundation for health, well-being and happiness.
Adoption of the Declaration of Astana

Following the speeches from high-level panellists, Yelzhan Birtanov, Minister of Health Care of Kazakhstan, introduced the Declaration of Astana. The declaration, a recalibration of the Declaration of Alma-Ata for the 21st century, was produced with input from over 1,000 experts from across the world, and had gone through several rounds of public consultations, followed by intense Member State consultations. The final declaration was achieved with unanimous consensus. As Minister Birtanov pronounced the declaration adopted, he extended his congratulations to all those present for their part in the historic occasion.

Ministerial lunch

The adoption ceremony was followed by a ministerial lunch, where guests were received by Kairat Abdrakhmanov, Minister of Foreign Affairs of Kazakhstan. He congratulated guests on the adoption of the Declaration of Astana, and expressed his pride that delegates had been able to come together to agree on a declaration that would pave the way for the future. Recalling the government’s recent decision to create a national coordination centre for the implementation of the SDGs, he offered the friendship and assistance of Kazakhstan, especially to colleagues from the developing world, in their efforts to advance health. The Declaration of Alma-Ata had taken place in 1978, during the period of the Soviet-type Semashko model health system that Kazakhstan had inherited, and which today Kazakhstan was enriching through its own experience. He urged guests to consider Astana as a reliable partner in the further promotion and achievement of the SDGs in a culture of peace and unity.

Moderator James Chau then invited brief interventions from the assembled guests. Emiko Takagai, State Minister of Health, Labour and Welfare of Japan, welcomed the Declaration of Astana as an ideal opportunity to raise political commitment. Although there were many different routes to universal health coverage, three key factors had enabled Japan to achieve universal health coverage in 1961. The first was strengthening primary health care by strengthening the health workforce; the second was strong commitment from the financial sector; and the third was a mechanism for regular monitoring of quality and access.

Seth Berkley, Chief Executive Officer, Gavi, the Vaccine Alliance, noted that although vaccines were the most cost-effective health care intervention, they required the support of a primary health care system. The challenge was to build out that system to ensure that there was progressive universalism.

Marijke Wijnroks, Chief of Staff of the Global Fund to Fight AIDS, Tuberculosis and Malaria, echoed that point, noting that without robust systems in place it would be impossible to sustain and build on the gains made against key infectious diseases.

Tim Evans, Senior Director of Health, Nutrition and Population at the World Bank Group, remarked that from the Bank’s perspective there were three critical ingredients needed for the fulfilment of the Declaration of Astana and the SDGs. The first was to build the political demand to invest in people, health and education, with a view to improving human capital; the second was to put the front line first in every health system, and to ensure that every child, everywhere, was vaccinated; and the third was to beat the drum on domestic resource use. Finally, he noted that every country in the world could afford to implement universal health coverage by 2030.

The ministerial lunch concluded with the Minister of Health Care of Kazakhstan bestowing a special new award to mark the 40th anniversary of the Declaration of Alma-Ata. The award, for supporting primary health care, was awarded jointly to all countries of the world, and received ceremonially by the six regional directors of WHO and the UNICEF Director of Programmes, Ted Chaiban.
Youth lunch

Building on the discussions and outputs of the Youth Preparatory Workshop, young people organized a youth lunch where key ideas and messages were discussed and conveyed through exhibits that covered such themes as socially accountable education; capacity building and continuous learning opportunities for the health workforce; the role of technology, mobile applications, and social media in promoting health and health awareness; and frameworks and tools for youth engagement and empowerment on primary health care. Furthermore, from a rights perspective, lunch participants discussed the importance of leaving no one behind, fighting stigma and discrimination, and ensuring community participation in every step from planning to feedback mechanisms.

The youth lunch exhibits were visited by the Director-General of WHO and the Executive Director of UNICEF, as well as a number of other delegates who engaged in an interactive exchange with the young people during the lunch.
Second plenary session: the future of primary health care

Moderator
Ilona Kickbusch, Adjunct Professor, Graduate Institute of International and Development Studies, Geneva, Switzerland

Key messages

• Speakers paid tribute to the architects of the original Declaration of Alma-Ata.

• New technology has the potential to transform the way health care is delivered. In particular, the revolution in connectivity has the potential not only to broaden access to primary health care and training, but also to help identify areas where access is lacking.

• Innovations in the way health is financed can help incentivize health promotion and disease prevention, to rebalance systems that are currently too focused on curative interventions.

The second plenary session began with the bestowment of a special award dedicated to the 40th anniversary of Alma-Ata on Toregeldy Sharmanov, one of the architects of the declaration and a previous Minister of Health of Kazakhstan. Receiving the award, Dr Sharmanov expressed his thanks and his happiness that, 40 years after Alma-Ata, it was possible to say that the declaration had been a success, although there were still challenges. The new Declaration of Astana, he hoped, would successfully address those challenges, and 40 years from now we would be able to celebrate the successful Declaration of Astana.

Introducing the theme, Professor Kickbusch noted that the idea of passing the baton to the next generation was one of the recurring themes of the Conference. The present generation was passing on many problems, but could offer assistance and guidance to the next generation by passing on the Declaration of Astana. Never before in human history had there been so many children growing up at the same time. By 2035 all of them would be adults. That generation was here now, and wanted to see their lives changed. We needed also to discuss the economic and geopolitical shifts that were taking place, with 85% of people living in emerging economies – it was a priority to build for them and indeed with them.
Jay Walker, Curator of the TEDMED network, spoke of the importance of connectivity. He gave a brief recap of the history of writing, printing, the invention of the scientific method, the creation of mathematics and probability, and then the invention of the first mobile telephone 45 years ago. There were now more mobile phones in the world than toothbrushes. Connectivity was the future of primary health care. Connection was the past brought alive; it was the power of printing, speech, language, and data, and gave us the power to collapse space and time, knowledge and ideas. It also provided new opportunities to connect people across continents and across generations.

Robbie Bedbrook, a youth delegate from the Australian nongovernmental organization Hot on Health, agreed that connectivity cut across everything, and crucially, it enabled young people to be more visible and better represented in decision-making processes. It was important to involve young people in overhauling health systems. In the new Astana document, young people were not explicitly mentioned as stakeholders. As a primary health care nurse, Bedbrook pointed out that a wealth of good platforms existed that patients could access for information, and that our relationship with technology was becoming deeper, with phone applications now being used as an adjunct to treatment in some cases.

Seth Berkley, Chief Executive Officer of Gavi, the Vaccine Alliance, pointed to the crucial role that technology played in identifying underimmunized populations. If we could identify where the pockets of underimmunization were, then we had a hope of building a system with health care workers, supply chains, and all the components needed not only to vaccinate people but also to provide other interventions as part of the efforts to build an equitable primary health care system.
Shin Young-soo, WHO Regional Director for the Western Pacific, noted that universal health coverage was one of the three overarching goals of the WHO 13th General Programme of Work, with Member States united around a vision for primary health care. But to bring that vision into reality we must learn from history. The Alma-Ata vision was just as relevant today as it was 40 years ago. However, the socialist economies of the 1970s had mostly been replaced by market mechanisms, and over the same period, the Millennium Development Goals had focused on specific disease-reduction targets. The combination of a fracturing of health care by market mechanisms and the focus on vertical, disease-specific programmes had created a situation inconsistent with Alma-Ata. All countries in the Western Pacific Region faced shared challenges, including ageing societies and growing burdens of noncommunicable diseases. All needed a primary health care system fit for the 21st century.
Verónica Espinosa, Minister of Public Health for Ecuador, said that, despite Alma-Ata, inequality was rising. In Latin America many countries had built universal health care systems, but still observed increasing inequality in health care provision. The biggest challenge to narrowing those inequalities was mobilizing the political will linked to action. A number of important issues had not been included in the Declaration of Astana. There was a need to approach gender inequities rather than gender issues, and to discuss the roles of governments and regulation, and the commercial determinants of health.

Jagat Prakash Nadda, Minister of Health and Family Welfare, India, stated that India would soon become the most populous country in the world. The country therefore had to opt for large-scale programmes. After success in achieving the Millennium Development Goals the country was now concentrating on trying to reduce the burden of noncommunicable diseases through a number of initiatives, including sensitizing young people, converting 150,000 health centres into health and wellness centres, and incorporating universal screening for hypertension, diabetes and cancer. Political will was a major element of that process.

Brett Giroir, Assistant Secretary for Health, United States Department of Health and Human Services, said that the United States strongly and enthusiastically supported the critical importance of primary health care. The first priority of his department was access to affordable, high-quality health care, starting with primary care, and there were diverse strategies to achieve that. The federal government provided care along with faith-based organizations, academic centres, and private providers, forming a collage of care. The health care system in the United States was undergoing a transformation from one that rewarded the care of the sick to one that rewarded providers for keeping people healthy – in essence, where you put your rewards was where you got your health. Incentives also drove innovation in the system. Access, health for all, transforming to health promotion, and reducing the costs of drugs and other services were all factors that could enhance the delivery of the vision of the Declaration of Astana.

Ainur Aiypkhanova, Director-General of the Kazakhstan Republican Centre for Health Development, drew attention to the importance of innovations and digitalizing health, and the need for regulators to be proactive rather than intervening late and battling against uses of new technologies. The point was echoed by the Minister from India.
Third plenary session: making the economic case for primary health

Chair
Seyed Hassan Ghazizadeh Hashemi, Minister of Health and Medical Education, Islamic Republic of Iran

Moderator
Jay Walker, Curator, TEDMED, United States

Key messages

- In order to convey the economic case for investment in primary health care effectively, health ministers must communicate in simple language, present a concise and compelling argument that clearly sets out the positive returns on investment, and be tenacious.

- Demonstrating good stewardship of public resources is crucial to any argument for more resources.

- Human capital contributes disproportionately to growth across countries across time.

- Primary health care is a smart investment.

The third plenary session was chaired by Seyed Hassan Ghazizadeh Hashemi, Minister of Health and Medical Education of the Islamic Republic of Iran. He said that the primary health care-oriented health system instituted in the Islamic Republic of Iran had had a great economic impact. By fulfilling the needs of the community it had reduced the burden on hospitals and prevented the high costs associated with late diagnoses and poor follow-up.

Moderating the session, Jay Walker, Curator of the TEDMED network, stated that while there was no doubt that primary health care was of great importance, or that universal health coverage was a goal that all countries sought to establish as quickly as possible, the challenge was money. The ministry of finance has the unenviable job of fielding requests from every other part of government. The challenge for health ministers and others was to persuade the ministry of finance to allocate the funds required.
Keynote speaker Hans Kluge, Director of Health Systems and Public Health, WHO Regional Office for Europe, described the experience of the European Region, which had been disproportionately affected by the financial crash in 2008. After a dialogue with finance ministers, WHO had identified four key objectives that any argument for extra resources needed to satisfy:

- Demonstrate good stewardship of public resources
- Promote macroeconomic growth
- Support societal well-being
- Ensure fiscal sustainability.

One of the biggest problems was communication between the different ministries. Health and finance had different “languages” and often different time horizons. Health interventions by their nature were often designed to deliver long-term benefits. But during the economic crisis in Greece, for example, governments had been asked to make decisions within 24 hours. Primary health care had numerous macroeconomic benefits, he continued. Having a healthy workforce was a macroeconomic win–win. An increase in life expectancy of 5 years increased GDP by 0.58% on average. Primary health care also had microeconomic benefits. Treatment in hospital was much more costly than in households, for example. In a study of five countries in Europe, around half of all hypertension and diabetes cases treated in hospital could have been managed in the community. Primary health care also offered a platform to tackle preventive measures, and to treat patients with multiple morbidities.

Alikhan Smailov, Minister of Finance of Kazakhstan, pointed out that all countries faced the challenges of increasing life expectancy, an increasing burden of chronic diseases, and increasing costs from the introduction of new medical technologies. Primary care was the solution to those challenges; it was the only way to provide medical services to a growing population while taking into account inclusion and economic growth. In 2018, health care system financing in Kazakhstan was equal to just over 3% of gross domestic product (GDP). That level of financing was not sufficient to provide the population with the required services, with out-of-pocket payments accounting for approximately 40% of total health care expenditure. To remedy that, a system of compulsory social health insurance would be implemented in 2020 in order to increase the effectiveness of the health care system and provide sustainable universal health coverage. Effective resource allocation, the right choice of priorities, and inclusiveness played fundamental roles for health care systems in all countries.
Pungkas Bahjuri Ali, Director of Community Health and Nutrition at the National Planning Authority, Indonesia, said that a common language could be established around the need to reduce poverty, reduce inequity, and boost human capital, but creating understanding was not easy. For example, the treatment of disease was always more visible, and therefore more politically powerful, than prevention. Leadership was crucial. Driving efficiency was also vital, particularly when the fiscal space was not growing rapidly.

Harinirina Yoël Honora Rantomalala, Minister of Health of Madagascar, agreed that health was one of the main motors of productivity. In Madagascar, one of the main barriers to instituting equitable access to health care had been a lack of human resources. Since 2015 the country had invested in education to ensure the quality, quantity, and necessary diversity of health workers to deliver primary health care.

Poonam Khetrapal Singh, Regional Director of the WHO Regional Office for South-East Asia, pointed to the fact that health budgets were increasing in 60% of the countries in the region as evidence that finance ministers were receptive to the arguments put to them. Ministers of finance must realize that by investing in primary health care they could get more out of spending less. But just putting more money into the system was not enough. Often systems needed reorganization and reprioritization, and a greater emphasis needed to be placed on building the linkages between different ministries, such as those dealing with sanitation.

Søren Brøstrum, Director-General of the Danish Health Authority, reported on a recent success for his department in securing funding for a four-year action plan on mental health totalling around 300 million euros. Although more funding was still needed, the plan represented success in terms of persuading the minister of finance to allocate significant funding. Regarding the question of how best to have a dialogue with the ministry of finance, the key steps were to state a convincing business case and keep it simple.

Denmark was a high-income country, spending around 12% of GDP on health. One-third of all public spending in Denmark was on health care, so it was not politically feasible to argue for more funds to be paid for through general taxation. To get the attention of the finance minister, any new initiative must demonstrate that it could achieve the following.

- **Get more health care for the money.** Hospital services were always more expensive than similar services delivered outside hospitals.

- **Deliver better health care for the money.** Hospitals were geared for sick people and complicated diseases, but tended to overdiagnose and overtreat. Primary health care could often deliver more effective care for many conditions.

- **Shift services outside hospitals and into communities of primary health care.** That would enable hospitals to provide better-quality core services. A hospital would tend to lose focus on its core competences if it had too many patients.
Kanuru Sujatha Rao, former Union Secretary of the Ministry of Health and Family Welfare, India, pointed to the constant tension between investing in hospitals and primary health care in India. The ability of the government to inject more money would always be a challenge when the strong links between health and macroeconomic fundamentals were not recognized.

Tim Evans, Senior Director of Health, Nutrition and Population at the World Bank Group, reported on the Bank’s recent analysis of what drove growth through time. The Bank found that human capital contributed disproportionately to growth across countries over time. The findings were important because for a long time the Bank had neglected the importance of human capital, thinking of it as something that could be afforded once high-income status had been achieved, rather than as a driver of sustainable growth and development. There had been many arguments related to returns on investment in health. Finance ministers were lobbied on a daily basis on why one sector or another should be invested in, so it should not be assumed that any argument, however convincing, would be remembered. It was necessary to constantly wave evidence under the minister of finance’s nose. When it came to demonstrating good value for money, there were three critical domains of evidence.

- **Choice.** How would you know you were choosing the right interventions? For instance, was training midwives more cost-effective than investment in subspecialties? Was taxing tobacco better than treating lung disease?
- **Delivery.** There were two main areas of efficiency:
  - **Ethics.** If money went missing, you struck out.
  - **Scale.** If you were not working at scale by using, for example, one electronic identification document, or one procurement pool, then you were missing value.
- **Equity.** If you were not delivering to economically, geographically, and socially marginalized communities then you were not doing your job.

The next question was, “What evidence makes a difference?” We had to invest in evidence at the same time as recognizing that the future was uncertain, with changing burdens of disease, emerging epidemic diseases, and changing technologies.

Towards a global action plan for healthy lives and well-being for all

The Astana Conference was the perfect opportunity to launch a radical new global action plan to accelerate progress towards SDG 3. The plan was developed at the request of the governments of Germany, Ghana and Norway, and brought together 11 agencies to coordinate and align their efforts more closely: Gavi, the Vaccine Alliance; Global Financing Facility; Global Fund to Fight AIDS, Tuberculosis and Malaria; Joint United Nations Programme on HIV/AIDS (UNAIDS); United Nations Development Programme (UNDP); United Nations Population Fund (UNFPA); UNICEF; UNITAID; UN Women; World Bank Group; and WHO.
Fourth plenary session: driving equity through primary health care

Chair
Nila Farid Moeloek, Minister of Health, Indonesia

Moderator
Christopher Elias, President, Global Development Division, Bill & Melinda Gates Foundation

Key messages
- Societies have a moral obligation to help their most vulnerable citizens.
- It is crucial to identify exactly where inequities in access and outcome are.
- Examples from all WHO regions show that expanding access and tackling inequities are possible even in the face of limited financial resources, as long as the political will is present.

Forty years ago, Christopher Elias recalled, the global community did not come together very often. But it had come together in Alma-Ata around the powerful idea of health for all, and the same idea united the participants at the present meeting.

The session’s first speaker, Dereje Wordofa, Deputy Director of UNFPA, acknowledged that today human rights and the principle of leaving no one behind were at the core of the 2030 Agenda for Sustainable Development. But many inequities remained and needed to be addressed. And to respond to those inequities, it was necessary to measure the essential components of equity. Strong health service information systems could help us understand barriers, and geospatial analyses could pinpoint the exact locations where populations were underserved. Those techniques were already contributing to a more equitable distribution of life-saving interventions, such as insecticide-treated nets and vaccinations in Nigeria.
Madina Abylkasymova, Minister of Labour and Social Protection of Kazakhstan, updated the Conference on the country’s plans to introduce compulsory social and health insurance by 2020. Due to the large proportion of the population engaged in informal employment or self-employment, new types of enrolment mechanisms had been developed to simplify regulations for people not willing or unable to register through a business. For equitable access, it was important to provide such simplified support.

Andreas Xanthos, Minister of Health of Greece, remarked that in his view, Alma-Ata was a deeply political appeal for justice in the allocation of public health care resources, with universal health coverage cast as a dividing line between progressive and neoliberal health policies precisely because universal health coverage was a political choice that required commitment to the concepts of equality. Greece was a country that had suffered from the financial crisis and subsequent period of austerity, but over the previous three years the government had implemented a plan for the universal and equitable access of all citizens to the public health system. At present around 20% of the Greek population were uninsured, so the government had decoupled access to health from income, employment, and nationality or origin. During a period of budgetary constraints, the government had put an end to health spending cuts, increased human and material resources for the health system, and invested in primary health care. Health should be open to all, and primary health care was the key to that. Today, after the crisis, the challenge was to overcome any barriers caused by austerity and ensure that the right to health existed not only on paper. In the view of the Greek Government, universal health coverage and health equity strengthened social solidarity, and were a critical prerequisite for the rule of law and for democracy.

Sridhar Venkatapuram, Senior Lecturer in Global Health and Philosophy at King’s College London, United Kingdom, pointed to the moral obligation that societies had to protect their most vulnerable and marginalized citizens. The people who found themselves at the bottom of society were usually not there by accident, but rather as the result of domination.
Afshan Khan, UNICEF Regional Director for Europe and Central Asia, stated that investments in the health of young people would deliver the biggest gains over the long term, but inequalities were becoming very marked and the needs of adolescents and young people often went unrecognized. Further efforts were needed to increase the literacy of young people about primary health care.

Violeta Menjivar, Minister of Health of El Salvador, described her country’s move towards universal health coverage. The country was overcoming geographic, economic and technological barriers in order to establish free access to services, as well as carrying out important investment in health structures and human resources in rural areas and those areas with the highest poverty indexes. The country had created 576 community health teams, which had led to a number of positive changes including lower mortality rates, 99% of births attended by qualified staff, and a continued fall in infant mortality.

Matshidiso Moeti, Regional Director of the WHO Regional Office for Africa, offered several examples of how countries in the region had taken concrete steps to reduce inequities in primary health care. In Rwanda, financing to extend insurance to low-income households had enabled community-based health insurance to cover 90% of the population. In Ethiopia, the government had established a health extension programme to identify local women in rural areas and train them to provide basic health care services to the population.
Joia Mukherjee, Chief Medical Officer, Partners in Health, also pointed to Rwanda’s achievements, and stressed the fact that the Rwandan Government held itself accountable for the health care outcomes of the lowest quintile of the population, a key safeguard for improving equity. Proximity to suffering was also a key point related to access, which was one of the reasons that community health workers were an essential component for the provision of equity. She concluded by calling for a global financing scheme for the SDGs.

Summarizing the session, Christopher Elias noted that in order to seriously address inequities in access and outcomes, it was necessary to know where they were, and to go beyond interventions restricted to the health sector. The main take-home point from the session was optimism for the future, given the greatly increased knowledge about what worked and how to measure it.
Fifth plenary session: addressing health needs through primary health care

Chair
Leao Talalelei Tuitama, Minister of Health, Samoa

Moderator
Ariana Childs Graham, Director, Primary Health Care Initiative, United States of America

Key messages
- No single issue can be at the centre of the universal health coverage or primary health care agenda: it was necessary to move firmly beyond the vertical approach to health care to an integrated approach.
- Addressing the determinants of health will be the key to improving outcomes.

Minister Talalelei began by urging the medical community to do more to understand the effects of environmental change and degradation on health. For primary health care to address all needs, the Astana Conference should and must send out a strong message to the world about the impact of climate change on global health security.

Ariana Childs Graham noted that we were in the midst of a major move from a vertical approach to an integrated approach to health care that addressed the life course, and stressed that no single issue would be at the centre of the universal health coverage or primary health care agenda.
Alfredo González Lorenzo, Deputy Minister of Public Health, Cuba, noted that the functioning of the public health system in his country had always been based on the principles of universal access for the whole population. Over the past 10 years the government had taken measures to digitize the primary health care system, based on the restructuring of services to integrate research, clinical management and epidemiology. The availability of human resources had been a key factor in the success of primary health care in Cuba.

Ahmed Al-Mandhari, Regional Director of the WHO Regional Office for the Eastern Mediterranean, emphasized the importance of building trust with communities through family medicine, and the importance of continued professional development among family physicians to maintain the confidence of patients and colleagues.

Ulana Suprun, acting Minister of Health, Ukraine, updated the Conference on her country’s recent and continuing health care reforms, which put much greater emphasis on primary care. In designing the system, the individual choice of patients had been given weight. Patients were now able to choose their primary care physician from any facility, whereas previously patients were assigned to a physician. That was especially important in the context of internally displaced people, with around 1.7 million people displaced by the war in eastern Ukraine. The second significant change had been surrounding integration and access. Based on a capitation system, physicians were paid by how many individuals signed up, with an ehealth system freeing many patients from the previous burden of bureaucratic requirements. She concluded by noting that at present the biggest impediment to health for all in Ukraine was the conflict in the east of the country.

Vinay Saldanha, UNAIDS Regional Director for Eastern Europe and Central Asia, agreed with Childs Graham that leveraging the knowledge and passion of disease-specific programmes could be used to strengthen primary health care. There was no point in mopping up the floor of ill-health if you had not turned off the tap of ill-health caused by the determinants of health. There was also a need to create new and strategic pathways for women’s leadership, and a pressing requirement to ensure all health systems were free from stigma and discrimination. Billions of dollars were being spent on building health systems, but to be effective every single person coming through the door should be treated openly with dignity and respect.
Sixth plenary session and close: primary health care towards universal health coverage and Sustainable Development Goal 3

Key messages

- Speakers urged participants to ensure that Astana was the moment the world comes together to ensure that the right to health becomes a reality in the 21st century.
- Young people are the key to implementing the Declaration of Astana. They want to contribute and be held accountable.
- Primary health care must be seen as a launching pad for people, nations, and communities to thrive – as an investment, not a cost.

Moderators

Vidhya Ganesh, Deputy Director of Programme Division, UNICEF
Edward Kelley, Director of the Department of Service Delivery and Safety, WHO

Carissa Etienne, Regional Director for the WHO Region of the Americas, professed a sense of renewed hope and commitment because young people were demanding change; civil society, the guardians of the welfare of the poor and excluded, were engaged; and people everywhere were embracing the values and principles of primary health care. We knew what worked and what we needed to do, but we must ask ourselves what we should be doing differently. Primary health care was a strategy for health and well-being that was centred on individuals, families and communities – it was not the provision of a limited package of care for the poor. Primary health care called for access to quality, for addressing the social determinants of health, and for removing all barriers to access. And it required state action. Barriers must be systematically identified and broken down. Fragmentation of services and systems was a recipe for failure. We had arrived at an important juncture in the history of primary health care. Governments needed to honour the rights of their people; assume leadership; adopt coherent policies and regulations that strengthened health systems and made them equitable and resilient; train to create a workforce never before seen; and invest in health, not war. It behooved the Conference to ensure that now was the moment the world came together to ensure that the right to health became a reality in the 21st century.

Seth Berkley, Chief Executive Officer of Gavi, the Vaccine Alliance, noted the dramatic improvements in rates of immunization over the past 40 years, alongside the development of potentially revolutionary new technologies, but cautioned that increased focus on allocative efficiency was needed in the face of a strong pull to spend money on tertiary issues.
Mariam Claeson, Director of the Global Financing Facility, underlined the need to think about how we focused on neglected areas such as displaced people and migrants, fragile and vulnerable populations, and neglected interventions.

Kerry Pelzman, Senior Foreign Service Officer, United States Agency for International Development (USAID), expressed the agency’s support for the primary health care agenda, noting that USAID had an extensive 30-year history of working on primary health care. The organization continued to develop linkages between formal health systems and communities, and would continue to build on those efforts across multiple programmes. Strong and sustainable primary health care systems could play an important role as the basis for health security, promoting resilience against natural and anthropogenic shocks.

Batool Al-Wahdani, President of the International Federation of Medical Students, paid tribute to the many millions of young health care professionals across the world, and noted that primary health care could not exist without the younger generation. There was a very thin line between tokenism and real engagement with young people. Young people were prepared to be held accountable, and should work towards being held accountable. The Declaration of Astana was an important moment, and handing it to the younger generation was an acknowledgement that primary health care was in the hands of young people.

Itai Rusike, Executive Director, Community Working Group on Health, Zimbabwe, drew the Conference’s attention to an alternative declaration made by the People’s Health Movement. Drawing on the experience of Zimbabwe over the past 40 years, during which primary health care outcomes had improved, followed by deterioration, Rusike urged all African leaders present to summon the political will, community, and leadership in terms of domestic health financing to shape the primary health care agenda. Health development partners could then come in and play a complementary role. It was important that development partners supported civil society. He concluded by expressing the hope that the Declaration of Astana would reach not only national parliaments, but also the people. Primary health care was a people’s issue, and people needed to be placed at its centre.

Charlotte Marchandise-Franquet, Deputy Mayor for Health, Rennes, France, spoke on behalf of the Healthy Cities Network to endorse the Declaration of Astana, and called on cities to lead by example by creating healthy societies. Cities were global actors, and had the power to ensure that health policies were enacted at a local level. She urged more cities to sign up to the WHO regional healthy city networks, and to advocate health for all.

Zsuzsanna Jakab, Regional Director of the WHO Regional Office for Europe, urged participants to take up and engage in the political battle for primary health care. Astana, she said, should empower us to make primary health care a reality in all of our countries.
Key messages from ministerial parallel sessions

First ministerial parallel sessions: revitalizing primary health care for the 21st century to achieve universal health coverage

Building the primary health care workforce of the 21st century

- There must be investment in people that encompasses the empowerment of individuals and communities, with a recognition of the importance of skills, local context and health needs.
- Health systems should not be seen as a cost: they are drivers of health and economic development. Better health means higher productivity.

Integrating primary health care-based service delivery

- Ensuring populations receive the right care, at the right time, and in the right place, in accordance with their needs and the local context, requires effective integration of providers and care settings based on a strong primary health care system. This includes integrating public health in primary health care, as well as breaking the silos between primary care and hospital care.
- Imbuing practitioners with a public health mindset during clinical training to promote integrated care is vital, as is moving towards effective governance, capitation and value-based payment.

Antimicrobials: a vital but vulnerable resource

- Around 80% of antibiotics are used in animals: ministries of agriculture need to be included in efforts to rationalize antimicrobial use. At country level, there is a need for legislation to reduce antibiotics in animal feed.
- Investment in education is the key to preventing overuse.
- Consumer pressure is helping to raise public awareness.

Empowering people at the centre of primary health care

- People should be empowered to engage in their own health in their own community.
- Young people's views are often overlooked – young people must be involved in decision-making not only about their own well-being, but also about local and national policy.
- Health care workers should be empowered through policies that promote their well-being, and ensure they are engaged in decisions about their working environment.
Second ministerial parallel sessions: the future of primary health care

New technologies, innovations and research in primary health care

- Technology and health are intrinsically linked.
- Technologies must be considered within social, legal and ethical frameworks, regulated and integrated with health systems to reduce the potential challenges and to mitigate adverse outcomes, including unexpected consequences and unreasonable financial costs.
- Technology is only one aspect of care: the end user needs to be at the centre of technology use, development and innovation.

Educating and scaling up the primary health care workforce to achieve universal health coverage

- Recruitment and retention are the key issues.
- Training programmes that develop an entire primary health care team are the future of primary health care.
- Remuneration for primary health care clinicians should be aligned with the level of remuneration of other specialists. However, rewards go beyond money to include status and a sense of belonging to the community.
- Skills must be built to ensure rural family doctors are able to deliver comprehensive services.

Equitable primary health care for women, newborns, children and adolescents

- Primary health care is key to achieving equitable sexual, reproductive, maternal, newborn, child and adolescent health care.
- Investing in women’s rights, and sexual and reproductive rights, has broader societal benefits that promote equity.
- Digital technology in health care can address patient needs and empower patients to be involved in their own care.
Private sector engagement and primary health care

- The private sector plays a prominent role in health service delivery. In most countries a mix of public and private organizations deliver primary health care. It is therefore essential that health policies and strategies address the private provision of services and private financing, as well as state funding and activities. Only in this way can health systems as a whole be oriented towards achieving health goals that are in the public interest.

- Private sector actors involved in primary care are extremely diverse and cover a wide spectrum of entities of different sizes, from sole practitioners to large corporations, all with very different attributes and financial and social intentions. If properly regulated and managed, private service providers can contribute positively to efforts to improve primary health care. However, failing to properly regulate and manage private sector service providers creates serious threats to efforts to achieve health for all.

- Governments will need to use a variety of approaches, including accreditation, regulation, and strategic purchasing, to ensure that the right care is available and affordable for all, irrespective of ability to pay.

Primary health care that meets the needs of older people

- The world's population is rapidly ageing; health systems will need to adapt to respond to the growing health and social care needs of older people.

- Integrated care is the best approach to strengthen primary health care towards the needs of older people, and community-based care is essential, as is education and training of health care workers to meet the needs of ageing populations.

- Strong primary health care for older people requires a substantial number of workers trained in rehabilitation, and able to provide social care and support.
Third ministerial parallel sessions: driving equity through primary health care

Leaving no one behind through primary health care

- Finances have not followed the priorities. We must alter the economic model under which we operate.
- It is critical to know and engage with communities to understand their needs.
- It is not sufficient to provide access to services; services must also be of good quality.
- Mobile medical teams have proven useful in remote regions.

Strengthening health system resilience to prevent and manage emergencies through primary health care

- Primary health care is the first line of defence in emergencies, whether in acute or protracted crises. However, poor-quality primary health care can contribute to the escalation of emergencies through poor standards of infection prevention and control, lack of appropriate equipment, or untrained staff.
- Essential public health functions should be integrated with quality primary health care.
- Primary health care promotes global health security and health system strengthening.
- Emergencies can provide impetus for reform and acceleration of health system strengthening.

Intersectoral approach to primary health care and population health management: policies, interventions and services

- High-level commitment is essential for building appropriate intersectoral structures to ensure commitment without overburdening existing staff.
- Particular attention should be given to improving cross-disciplinary and organizational networks (for example with regard to education, or between specific industry sectors for environmental and workers’ health), taking into account the different types of expertise needed in prevention, including through engagement of the environmental and occupational health disciplines.
- Countries need to have multidisciplinary teams in place to properly assess population needs, to facilitate teamwork, to improve communication among specialists, generalists, and non-medics, and to ensure convening of different approaches.
- In addition, countries need to move beyond services to dealing with different settings, including with regard to regulatory functions and the built environment, as outlined in the Health in All Policies and OneHealth approaches. This requires a renewed look at the social, environmental and structural determinants of community health related to pollution, water and sanitation, and food systems.
Operationalization of primary health care at the community level

• Communities are active participants in the production of health services, and service providers should leverage social networks and support social accountability.

• Addressing the wider social determinants affecting the health of communities requires an integrated, multidisciplinary approach, involving non-health ministries as well as health ministries in front-line service delivery.

• Innovation, including technology, is needed to scale up access to quality services at the community level.

• Community health information systems are equally vital, and front-line service delivery and participation data should be incorporated into national reporting systems.

• Domestic resource commitments are key to mobilizing additional catalytic investments in primary care at the community level, from donors and other funders.

Access to vaccines, medicines and health products in primary health care

• Rising medication costs must be addressed in order to improve the sustainability of public financing schemes.

• Ensuring access to medical care and medicines for the populations that are outside the social security system is essential, but they must first be identified.

• Gavi, the Vaccine Alliance, has created a marketplace for discussions with vaccine producers. Tiered pricing has allowed increased profitability for producers as well as improved financial accessibility. New manufacturers have entered the market in a situation that is high volume and low cost.

• Innovation is needed in medications, vaccines and products, but also in service delivery systems to improve access and delivery.

• The costs of vaccines, medicines and products, and their relation to costs of research and development and production, need to be transparent.
Fourth ministerial parallel sessions: addressing health needs through primary health care

Rehabilitation: an essential component of primary health care
- Rehabilitation services should be integrated at the primary care level.
- Standardized referral systems for rehabilitation between levels of the health system are essential.
- Assistive technologies are an integral part of effective rehabilitative services.
- It is important to develop rehabilitation services that are empowering and people-centred.
- Effective rehabilitation relies on a multidisciplinary workforce.

Mental health in primary health care: illusion or inclusion
- There is no health without mental health.
- Establishing a well-organized primary health care system and a governance model that allows for growth in mental health services is a major challenge, but is essential.
- Competencies need to be transferred to general practitioners and front-line primary care practitioners to enable them to identify, care for and refer patients with mental health conditions. Many practitioners also lack the time needed to address mental health conditions.
- These challenges can be addressed by system strengthening, creating awareness about mental health, destigmatizing the need for care, and advocacy within health care systems, the community, and government.

Palliative care in primary health care
- Without investment in palliative care, supported by political commitment, we cannot achieve universal health coverage, and we also are failing in our ethical and moral obligation to provide health care as a human right.
- Palliative care is an essential part of primary health care. It builds on the core principles of primary health care in that it is people centred, coordinated, and continuous.
- Further work is needed to engage key stakeholders, health care providers, and patients to address the barriers to implementation of palliative care. This includes the need to address some social and cultural barriers to palliative care.
- Lack of access to essential controlled medicines is a key barrier that needs addressing at a global level.

Noncommunicable disease control in primary health care: changing the paradigm for service delivery
- Noncommunicable diseases are the leading cause of global disease and disability. Primary care must step up to perform a leading role in prevention and control.
• Diagnosis and management of noncommunicable diseases are generally not managed at the primary care level in most developing countries; they are often managed at hospitals, with a high cost. Furthermore, most primary care facilities do not have the necessary infrastructure, equipment or resources to diagnose and manage noncommunicable diseases.

• Multidisciplinary teams are well positioned to assume many of the roles traditionally undertaken by hospitals. Involving public health workers, social workers, and mental health professionals will enable primary care to deliver more comprehensive prevention and control of noncommunicable diseases.

• Primary health care teams also have a role in addressing social determinants of health; however, it is not entirely clear what this will look like in practice for many countries. More experimentation is needed here.

• Civil society needs to play an important and active role in linking primary health care teams to patients who live with noncommunicable diseases.

Ending the epidemics of high-impact communicable diseases: primary health care as the enabler

• Vertical programmes and primary health care must both be centred on equity – those affected are the poorest and most marginalized.

• Clinical management of communicable diseases (including health promotion, prevention, screening and treatment) is aligned with primary health care delivery.

• Until now we have followed a false dichotomy between noncommunicable diseases and communicable diseases – our focus must simply be on people.

• Good-quality care is required to create systems that are trusted by patients.
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