Canadian Public Health Association

POSITION PAPER

Sustainability and Equity: Primary Health Care in Developing Countries

1990

Sponsored by the CPHA Task Force on the Sustainable Development of Primary Health Care Services in Developing Countries

One of the most critical issues facing developing countries today is that of sustaining the gains made in health programs, particularly in strengthening and expanding Primary Health Care (PHC). During the past decade, health has held its own in terms of real financial allocations[1] of major western nations for Official Development Assistance (ODA) and in the share of such total assistance earmarked for health. Despite this, the debt crisis, increasing impoverishment, and conflicting national priorities in developing countries contribute to the need for increased support if the steady improvement in health status made during the past 40 years is not to be jeopardized. CPHA believes that its international health activities must be directed to meet this challenge.

CPHA, the major national organization representing community health leadership in Canada, is a significant participant in the strengthening of PHC in developing countries. CPHA, with the assistance of the Canadian International Development Agency (CIDA) and in partnership with the Canadian Non-Governmental Organization (NGO) development community, is currently collaborating in 102 projects in 54 developing countries through its programs to strengthen immunization programs and national public health associations.[2] In addition, CPHA has participated in international discussions on health development in such forums as the World Federation of Public Health Associations, the Commonwealth Health Ministers' Meetings, United Nations Children's Fund (UNICEF), the World Health Organization (WHO), and in the Canadian development community. This has given CPHA a unique perspective and expertise in the development process as well as the opportunity to contribute to discussions at the international level with respect to health programs.

Health services have long been considered a net consumer of national resources. This perception must change. A healthy population, capable of making full use of its mental, physical and spiritual potential, will thereby contribute to national development and international good. Expenditures in health must be more rightly seen as an essential investment in the future of humanity. The challenge of the 1990s is to find the just and equitable mechanisms to reach this goal.

Content of PHC as Defined in the Declaration of Alma-Ata

- Education concerning prevailing health problems, their identification, prevention and control;
- Promotion of food supply and proper nutrition;
- Adequate supply of safe water and basic sanitation;
- Maternal and child health care, including family planning;
- Immunization against major infectious diseases;
- Prevention and control of locally endemic diseases;
- Promotion of mental health; and
- Provision of essential drugs.

To assist the Association in establishing Guidelines and Strategies relative to the development of sustainable health programs, the CPHA Executive Board in November 1989 appointed a Task Force on the Sustainable Development of Primary Health Care Services in Developing Countries with the mandate:

- To review available literature with respect to sustainable development in health;
- To prepare a draft document consistent with CPHA's philosophy on health services;
- To receive input from national and international partners, staff, the CPHA Review and Evaluation Committee, and other designated persons, in the preparation of the Position Paper; and
- To prepare a Position Paper on the Sustainable Development of Primary Health Care Services in Developing Countries for submission to the Public Policy and Legislation Committee for presentation to CPHA's Annual General Meeting in June 1990.

1.0 Experiences of the 1980s

The 1978 WHO/UNICEF Conference in Alma-Ata, USSR, brought forth the Declaration of Alma-Ata. It is the clearest and most widely accepted articulation of a basic set of values for health as these relate to world development.[3] The Declaration has been endorsed by most countries, including Canada, with Primary Health Care identified as the key to achieve Health For All by the Year 2000. At this historic meeting, CPHA, on behalf of the World Federation of Public Health Associations (WFPHA), was privileged to present the position of the international non-governmental organizations in support of the Declaration of Alma-Ata.

Many advances in health have been made since the Declaration of Alma-Ata in 1978. The proportion of the population in developing countries with access to at least some PHC services, has increased.[4] Despite these gains, according to international sources such as WHO/PAHO, UNICEF, and the World Bank, 60 to 75 per cent of people in developing countries still lack access to basic primary health care.[5] Since 1985, the global drive to immunize children has been successful in strengthening PHC and in reducing infant mortality rates. However, much still remains to be done to build on these improvements and to achieve Health For All by the Year 2000.

At the same time as many developing countries were progressing towards this goal, the 1980s were becoming increasingly hard for the people in those countries. Conditions of civil strife and war dislocated many populations with grave repercussions on their health. In addition, the global recession severely affected many economies through price instability, deteriorating terms of trade, growing protectionism in developed market economies and increased costs of imports. These countries saw foreign debt and debt service charges mount with little realistic possibility of paying off their creditors or even covering the interest charges. These prevailing problems, coupled with declining aid contributions by some of the major donor nations, have placed the social programs in many developing countries in a crisis situation. Under these conditions, not only is progress unlikely, but achievements already made to date may be lost.

Over the past decade, worldwide trends show that disbursements for health varied within a range of 5 to 7 per cent of total Official Development Assistance,[6] with marked year-to-year fluctuations. Statistics provided by the Organization for Economic Co-operation and Development (OECD) indicate that annual allocations of Canadian aid for health ranged from 1.9 to 6.2 per cent of total Canadian ODA during the 1980s.[7] Much of this consisted of assistance to immunization and AIDS programs of fixed and relatively short duration. In Canada, ODA programs during the 1980s have also been affected by the global recession and efforts to reduce national debt, as reflected by the recent cut of ODA from 0.47 per cent of Gross National Product (GNP) in 1987 to the 1989 level of 0.43.[8]

Providing support to strengthen PHC in developing countries has been a priority of the Canadian government's international assistance policy for health during the past two decades. This was reconfirmed in Sharing Our Future, the official Canadian statement of aid policy, tabled in Parliament in 1987. While Sharing Our Future has a number of positive implications for strengthening PHC, these principles should be reflected in the development of a new CIDA health policy. The Association believes that a CIDA Health Policy should recognize that the sustainability of health programs is contingent on long-term commitment of both national and international funds to achieve a strengthened and self-sufficient PHC system. In light of the official strategies articulated in Sharing Our Future, a strong case can be made for increased Canadian ODA allocations for health programs.

1.1 Health and Poverty

Poverty is the biggest stumbling block to achieving a healthy population. The current international economic situation has led to a downward spiral for economic development in many developing countries. The basic economic relationship between developing and Industrialized countries must be addressed if the current situation is to improve. Health programs, to be effective and sustainable, must be delivered concurrently with other social and economic development activities.

An immediate preliminary step is to address the debt problem of developing countries. The estimated collective debt of developing countries is now about US$1 trillion, or one

Sharing our Future: Implications for Assistance in Health

- Focus on poverty alleviation;
- Attention to basic health problems;
- Mobilization of community resources and participation;
- Limiting the number of aid recipients with increased attention to low-income countries and small island states;
- Increasing support for human resource development;
- Strengthening partnerships with NGOs; and
- Support for environmental strategies.

DECLARATION OF ALMA-ATA, 1978 SUMMARY

Article I: "Health . . . is a fundamental human right and … the attainment of the highest possible level of health is a most important world-wide social goal of many other social and economic sectors in addition to the health sector."

Article II: "The existing gross inequality of the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries."

Article III: "Economic and social development, based on the New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and the developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to the better quality of life and to world peace.

Article IV: "The people have the right and the duty to participate individually and collectively in the planning and implementation of their health care."

Article V: "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social targets of governments, international organizations and the whole world community in the coming decades should be the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of the development in the spirit of social justice."

The basic philosophy of Primary Health Care (PHC) is described under the Declaration of Alma-Ata as follows:

Article VI: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. . . ."

The development of PHC is clearly identified not only as national priority for developing countries, but as an international mission in Article IX of the Declaration:

"All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any country directly concerns and benefits every other country."

thousand billion dollars.[9] While tremendous, this amount is in fact, only roughly equivalent to half of the debt of the United States in 1986.[10] The inability of some developing countries to meet debt payment schedules has led to declining investment. These elements combine to make it impossible for developing countries to broaden their economic base and to break out of the poverty cycle. Contrary to popular belief, more money is transferred from developing countries to the industrialized world than the reverse. UNICEF estimates that the net transfer for loans, aid, repayment of interest, and capital is at least US$20 billion a year leaving developing countries.[11] This implies that the export earnings of most developing countries are utilized for debt repayments, with little left for social or economic investments. Africa and Latin America, in particular, have grown poorer in the past decade, with negative effects on the health of their populations. In the poorest sectors of these countries, malnutrition and infant mortality have been rising after decades of decline.[12]

1.2 Responses to the Crisis of the 1980s

1.2.1 Structural Adjustment Programs

The response of the international financial community to the debt crisis has been to impose a series of Structural Adjustment Programs which include restructuring loan repayments, the reduction of national public sector expenditures, an increase of exports and reduction of imports as well as the removal of subsidies on staple foodstuffs. It was expected that these measures would eventually lead to economic recovery, thereby permitting a country to meet its debt obligations and to protect its eligibility for further credit and foreign investment. To date, while they continue to be widely applied, Structural Adjustment Programs have not yet resulted in demonstrable long-term economic recovery in any developing country.

These actions have had a direct effect on the health and well-being of the poor and middle class sectors of society. With food-producing lands increasingly being converted to export crops coupled with the removal of food subsidies, there has been an increase in hunger and nutritionally related diseases. Since most pharmaceuticals are imported and in many instances health sector expenditures have been reduced, the quality and quantity of services available have diminished. Unemployment has increased among the poor and low income sectors of society and access to health and education for their children is beyond their reach. In countries where statistics are available, UNICEF reports increased evidence of low birth weight infants, a sensitive indicator of the well-being of women.[13]

CPHA commends both the private and public sectors in a number of Industrialized countries, including Canada, which have initiated loan forgiveness programs. The Association believes that debt forgiveness is an essential, albeit a stop-gap measure, and that long-term improvements in life chances and living conditions are dependent on better terms of trade with developing countries. However, the problems caused by the debt crisis and Structural Adjustment Programs cannot be resolved merely by rescheduling loans to enable countries to maintain repayments. Only in the context of the larger international efforts to alleviate poverty will it be possible for health programs to be sustained. In addition, the reallocation of national priorities and the redistribution of wealth internally and internationally to improve the living conditions of the poorest are required. The restrictions on social spending imposed by Structural Adjustment Programs would not be acceptable within Canada. The Association believes it unethical to support programs abroad which are not subscribed to by Canadians at home.

1.2.2 "Adjustment with a Human Face"

Alarmed by the effects of Structural Adjustment Programs, UNICEF has called for "Adjustment with a Human Face" programs which would: protect the poor and vulnerable; undertake specific measures to alleviate poverty; target low-cost, high impact services such as PHC, primary education and basic water supplies; and which would, in addition, monitor human indicators of recovery policies as well as economic measures.[14]

While many donor countries including Canada have subscribed to Structural Adjustment Programs, the "Adjustment with a Human Face" approach has not yet gained international adherence. CPHA believes that a radical rethinking of indicators of development, which include both improvement of the human condition as measured by quality of life as well as economic indicators, is required and a recommitment made to the principles and values articulated in the Declaration of Alma-Ata.

1.2.3 Cost Recovery: a means of financing primary health care

The World Bank has responded to the diminished capacity to finance primary health care programs by proposing cost recovery, user fee and privatization policies, in addition to initiatives to increase community financing for health programs.

While some of these policies may, as intended, strengthen PHC in some countries or regions, a significant portion of the population of many developing countries do not even have sufficient money to purchase food for their families. User fees or the selling of essential medicines in such circumstances are regressive measures. The poor disproportionately experience more illness and disability than others. Community self-financing is impractical if the community lacks a sufficiently well developed economic base.

The Bamako Initiative, adopted by the WHO Regional Committee for Africa in 1987 as a strategy to finance PHC through the sale of essential medicines, has recently raised hopes in some quarters that a mechanism for financing PHC has been found and that community confidence in the health care system may be restored by ensuring essential drug supplies. The initial supply of medicines would be provided by donor countries with the intention that their sale in the community would generate sufficient resources to permit the continuous replenishment of the medical

supplies and financially self-sustain the primary health care services at the local level.

CPHA, along with a number of other organizations,[15] has registered its concern that these initiatives may compromise the basic principle of equal access to PHC. Numerous studies[16] have indicated that utilization of PHC drops off when user fees are introduced and that the "willingness" to pay for services or medicines does not equate with "ability to pay". Many families sell their land, incur debt or are obliged to be selective as to who in the family should receive health care. In addition, local cost-recovery programs must rely on a well-structured and administered health service to ensure that the financial resources benefit the community from which they were acquired.

The Association is also concerned that, in the current economic climate, a number of major aid organizations appear to be prepared to sacrifice equity in return for the promise of community self-financing of PHC through cost-recovery, even though there is insufficient research to determine if the idea is, in fact, viable.

The current trends in international health development run contrary to CPHA's long held position in Canada that people have the right to equal access to health care, regardless of their means. This principle is sustained financially in the operation of the Canadian hospital and medical insurance program as well as through general revenue, obtained by means of progressive systems of taxation and transfer payments to the Provinces and the Territories.

1.2.4 Selective Programming

With scarce funds available for health, some donor and developing countries have tended to concentrate their funding on selective health programs (e.g., major communicable diseases) which have the potential of showing short-term measurable results. However, the gains thus realized may be quickly lost if there is not an adequate PHC infrastructure in place to assume responsibility when a selective program ends. Difficulties also arise when selective programs compete for limited national and international funds and expertise required to establish and sustain the PHC system.

The most effective strategy is the establishment and maintenance of at least a minimally functional PHC system in every country, which would have the capacity to absorb elements of disease-specific health programs. This would provide the infrastructure necessary to deliver both basic and selective elements of health programs consistently at the community level.

2.0 Towards a Definition of Sustainable Development of Primary Health Care Services In Developing Countries

Existing definitions of Sustainable Development in health are limited to the financial sustainability of health programs. CPHA recognizes that there are no easy answers to the dilemma of the funding of PHC. The Task Force found existing definitions inadequate and has developed the following definition based on the principles of Alma-Ata and CPHA's commitment to equity.

The CPHA Definition:

A Primary Health Care system must be sustained not as an isolated entity, but as an integral part of an overall strategy for social and economic development at the local, regional, national and international levels. This is measured not only by the absence of disease, but by evidence of improvements in access to health care, the quality of life and the availability of opportunities for all members of society.

The capacity of communities to participate in the necessary changes to the social, environmental, financial and technical structures is essential to the sustained development of primary health care services. This builds upon local health knowledge and resources and enables individuals, families and communities to participate in attaining their own vision of health.

The main components required to achieve sustainable development of PHC services are:

- Technical sustainability (development and maintenance of the necessary cadre of appropriately trained people to meet the needs at the local level);
- Social sustainability (development and maintenance of community support for the program as well as the capacity within the community to play an effective role);
- Political sustainability (development and maintenance of the political will necessary to sustain a major policy direction);
- Financial sustainability (provision of adequate human and material resources); and
- Managerial sustainability (development and maintenance of the capacity to direct and plan effective services responding to demonstrated needs).

3.0 Challenges for CPHA In the 1990s: Goals and Strategies

We believe that improved health is integral to the development process. The attainment and sustainability of PHC must not be viewed only as a national responsibility but as an international commitment based on the principles of social justice as set out by the Declaration of Alma-Ata.

Following the Alma-Ata Conference, CPHA began its first collaborative activities with developing-country organizations in support of PHC. A major milestone was reached in 1985 when CIDA signed its first block-funding agreement with CPHA which established the International Health Secretariat. International development staff were recruited and formal structures within CPHA were set up. This infrastructure greatly enhanced CPHA's capacity to implement international health programs, it was a critical factor in CIDA's decision to ask CPHA to be the lead agency for Canada's International Immunization Program (CIIP).

In addition to strengthening public health associations in developing countries and managing CIIP, CPHA has implemented an International Health Awareness Program to keep the Association's membership informed about and involved in its international health activities. The Association is collaborating closely with the Canadian Society for International Health, the University of Manitoba and McMaster University in the development of an AIDS control program in Southern Africa.

These activities have given CPHA a wealth of experience and knowledge of the health conditions and health care systems of many developing countries as well as earning for the Association a significant role in international health development.

In light of this experience and the crisis faced by developing countries in sustaining the gains made in PHC, the Association has reexamined its position in relation to international health development. In the context of CPHA's definition of sustainable development in health, our commitment to equal access to PHC, and our belief that equity should be achieved through redistribution and reallocation of national and international resources, the following goals and strategies for the sustainability of primary health care services are set for CPHA for the next decade.

3.1 Goals

The overall goals are:

- To promote and strengthen Primary Health Care as the cornerstone of the Global Strategy to achieve Health For All by the Year 2000
- To strengthen partnership and collaborative activities between Canadian public health workers and their colleagues in developing countries;
- To promote leadership in public health through strengthening public health organizations in developing countries;
- To promote and strengthen the contribution of the Non-Governmental Organization community in support of national Primary Health Care strategies and activities; and
- To provide information about and advocate Canadian support for international health development policies.

3.2 Strategies

The Task Force on Sustainable Development of Primary Health Care Services in Developing Countries has identified a specific mandate for CPHA in relation to five strategies:

- Strengthening Primary Health Care;
- Fostering Partnership;
- Public Health Leadership Development;
- Mobilization of the Canadian Public Health Community for International Development; and
- Advocacy for international health developpment policies.

3.2.1 Strengthening Primary Health Care

The capacity of local health services in developing countries to maintain a high quality of service, maximize existing resources, and absorb additional programming initiatives needs to be strengthened. New programs are often implemented without due consideration about their effects on the capacity of primary health care workers to deliver service, or to the needs of the health care structure to supervise and assist community health workers adequately. With respect to these needs, CPHA will direct its program activities to strengthen:

- Community participation as a strong and vital component of community health programs;

- The creation of opportunities for communities to participate in the design and implementation of their own programs;
- The integration of scientific health care and traditional health systems;
- The information-gathering capacity to permit adequate planning and coordination of health programs;
- The managerial capacity of health administrators;
- Training and in-service education programs for PHC workers and their supervisors;
- The skills of primary health care workers in initiating and participating in the community development process; and
- The expansion of the International Health Human Resource Register in Canada and its extension to include public health professionals in developing countries.

3.2.2 Fostering Partnership

Liaison and collaboration with other public health and development organizations is an essential component of achieving Health For All by the Year 2000. Building upon its established international partnerships, CPHA will work closely with:

- Public health associations in developing countries to strengthen their capacity to contribute to and influence public health and environmental health policy;
- Canadian and developing countries' NGOs to strengthen health programs; and
- CIDA, WHO/PAHO, the World Bank, UNICEF and other major donor and international agencies and organizations in the implementation of health programs.

3.2.3 Public Health Leadership Development

Leadership is required for national governments to set Health For All by the Year 2000 as a priority, for national ministries of health to develop long-term plans towards the achievement of these goals and for donor countries to continue ongoing financial and technical support to strengthen PHC services. In addition, the experiences and skills of public health workers in developing countries should be communicated and more broadly shared. In particular, the specific contributions of women in the health sector must be better recognized and encouraged. CPHA will facilitate:

- The interaction and exchange of experience between public health workers in developing countries and through expanded South/South dialogue;
- The development of community leadership and processes of community participation in health programming;
- The development of skills for intersectoral collaboration; and
- The increased dissemination of research and program experiences of developing country public health leaders through assisting in publication of their materials and increased participation in international forums.

3.2.4 Mobilization of the Canadian Public Health Community for International Development

As a major participant in community health development, CPHA has a responsibility to inform the Canadian public and, in particular, Canadian public health workers about international development issues and to mobilize support in Canada for these programs. CPHA will develop programs:

- To provide a national forum for analysis and dialogue for Canadian health workers and CPHA membership on international health issues;
- To facilitate an exchange of experience between front line public health workers in Canada and developing countries;
- To promote publications in Canada on international community health issues;
- To carry out educational and awareness activities for CPHA members on international health development; and
- To seek funds to establish an interorganizational and interdisciplinary committee to monitor the experiences of cost-recovery programs and other efforts to achieve financial sustainability of primary health care service and, to monitor the protection of the principle of equal access to PHC.

3.2.5 Advocacy for International Health Development Policy

In light of the still widespread limited access to basic primary health care and the economic crisis faced in developing countries, there is an urgent need to reaffirm the political commitment made in the Declaration of Alma-Ata to the principles of achieving Health For All by the Year 2000 and the right of equal access to health services as a common social goal. In this context, priorities for advocacy by the CPHA are:

- Increasing the level of official and NGO development assistance for health;
- Restoring the Canadian Government's goal of allocating 0.7 per cent of GNP to ODA by the Year 2000;
- The operationalization for the health sector of the broad principles and social goals in the CIDA document, *Sharing Our Future*;
- Support for health and other social programs as a priority for developing countries' national allocations;
- Allocation of international support for health programs on a long-term basis in the context of the overall development process;
- Increased donor collaboration with governments and NGOs for strengthening PHC; and
- The undertaking of research on the impact and effectiveness of cost recovery programs and the development of health indicators and policies within the context of PHC services.

4.0 Conclusion

CPHA recognizes that neither health nor health care programs can be sustained on a long-term basis in face of entrenched poverty in most developing countries. A prerequisite to improving conditions of life for most people in the developing world is through a realignment of the economic relations between industrialized and developing countries.

CPHA, through its endorsement of the principles of the Declaration of Alma-Ata, and the adoption of the CPHA position paper on Healthy Public Policy, supports a broadly based approach to development in health which requires close collaboration with all sectors in addition to the health sector. In accordance with the international principles of social justice outlined in the Declaration of Alma-Ata, this collaboration must extend beyond national borders. CPHA recognizes that the attainment of PHC is integral to a broad and inclusive approach towards development, and is not limited narrowly and exclusively to health care services.

Currently, the idea of Sustainable Development of PHC has been narrowly defined in many quarters as the attainment of financial self-sufficiency when foreign funding ends. CPHA challenges this perception. Our approach defines the development of sustainable health programs as the process of integrating broad community involvement at all levels within the PHC system. The financial requirements of attaining and sustaining PHC must not be met by imposing an increased financial burden on the poorest and most vulnerable in society, but rather by redefining national priorities and redistributing national resources, a system of progressive taxation and increased international assistance to alleviate poverty and in support of social and health programs.

REFERENCES

1. Constant dollars for the decade ending 1987-88.
2. List of projects and countries available.
3. WHO, Alma-Ata 1978, Primary Health Care: WHO, UNICEF, 1978.
4. UNICEF, State of the World's Children 1989. Toronto: Oxford University Press, 1989.
5. UNICEF, *Ibid*.
6. CIDA defines Official Development Assistance as those funds approved by Parliament to assist developing countries.
7. OECD, Strengthening Development Cooperation For Primary Health Care: A DAC Concern, OECD, Paris 1989.
8. Government of Canada Budget, 1989.
9. CIDA, Sharing Our Future, Supply & Services, Hull, 1989, p.57.
10. George S. A Fate Worse Than Debt. London: Penguin Books, 1988, p.12.
11. UNICEF, *op., cit*., p.15.
12. UNICEF, "Adjustment with A Human Face", State of the World's Children 1987. Toronto: Oxford University Press, 1987, p.91.
13. UNICEF, State of the World's Children 1990. Toronto: Oxford University Press, 1990, p.15.
14. UNICEF, Adjustment with a Human Face. Oxford: Oxford University Press, 1987.
15. Statement on the Bamako Initiative, Christian Medical Commission of the World Council of Churches, Geneva 1989.

16. Stinson W. Potential and Limitations of Community Financing. World Health Forum 1984, Vol. 5; and de Béthune X, Shesoko A, Lahaye J-P. The influence of an abrupt price increase on health service utilization: evidence from Zaire. Health Policy and Planning 1989; 4(1): 76-81.

NOTES ON TERMINOLOGY

In the context of the Position Paper, the terms sustainable development, equity and equal access to PHC are used as follows:

Sustainable Development: This was defined by the Bruntland Commission as ".... development that meets the needs of the present without compromising the ability of future generations to meet their own needs." While this definition specifically applied to environmental issues, it has been appropriated by other sectors, such as health, to apply to the sustainability of development initiatives in health programs. Existing definitions of Sustainable Development in the health sector were found by the CPHA Task Force to be wanting. The Task Force has consequently developed a definition for CPHA.

Equity: The Declaration of Alma-Ata, 1978, was the first world-wide agreement which identified equity in health as a common social goal. This was interpreted to reflect the belief that health is a fundamental human right of all citizens of the world to permit them to lead a socially and economically productive life. The Declaration called for a new approach to health and health care to close the gap between the "haves" and "have-nots" and to achieve a more equitable distribution of health resources.

Equal access to PHC: PHC, as the first level of contact of individuals, the family and the community with the national health care system, was incorporated into the Declaration of Alma-Ata as an essential strategy to achieve the social goal of equity in health.