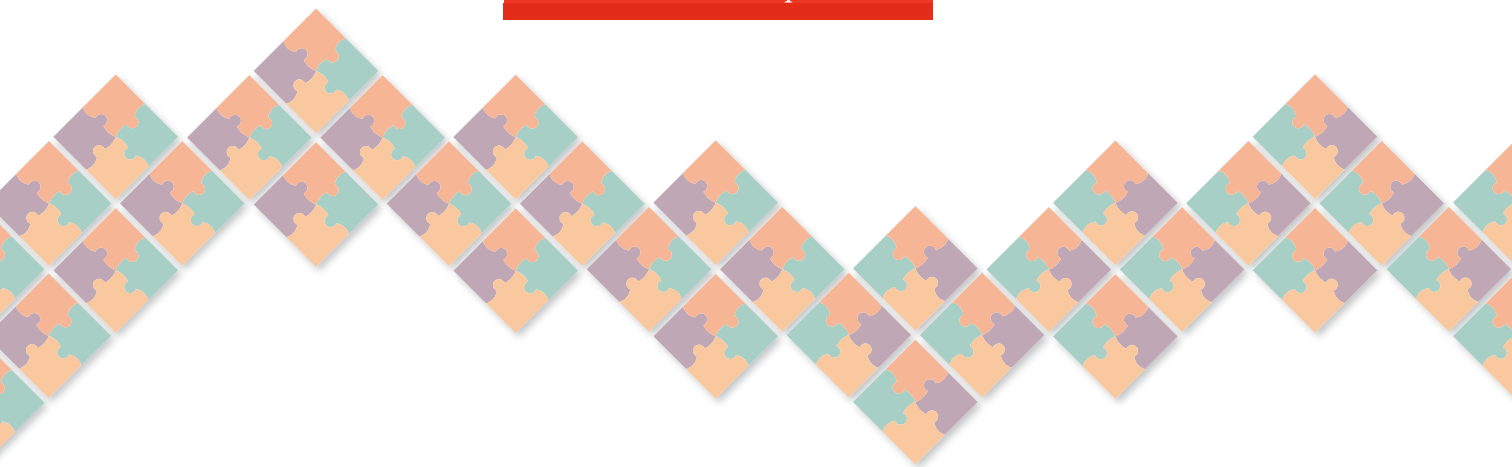
Introduction and Overview

The World Health Report **2008**



Primary Health Care

Now More Than Ever

World Health Organization

Director General's **Message**

When I took office in 2007, I made clear my commitment to direct WHO's attention towards primary health care. More important than my own conviction, this reflects the widespread and growing demand for primary health care from Member States. This demand in turn displays a growing appetite among policy-makers for knowledge related to how health systems can become more equitable, inclusive and fair. It also reflects, more fundamentally, a shift towards the need for more comprehensive thinking about the performance of the health system as a whole.

This year marks both the 60th birthday of WHO and the 30th anniversary of the Declaration of Alma-Ata on Primary Health Care in 1978. While our global health context has changed remarkably over six decades, the values that lie at the core of the WHO Constitution and those that informed the Alma-Ata Declaration have been tested and remain true. Yet, despite enormous progress in health globally, our collective failures to deliver in line with these values are painfully obvious and deserve our greatest attention.

We see a mother suffering complications of labour without access to qualified support, a child missing out on essential vaccinations, an inner-city slum dweller living in squalor. We see the absence of protection for pedestrians alongside traffic-laden roads and highways, and the impoverishment arising from direct payment for care because of a lack of health insurance. These and many other everyday realities of life personify the unacceptable and avoidable shortfalls in the performance of our health systems.

In moving forward, it is important to learn from the past and, in looking back, it is clear that we can do better in the future. Thus, this World Health Report revisits the ambitious vision of primary health care as a set of values and principles for guiding the development of health systems. The Report represents an important opportunity to draw on the lessons of the past, consider the challenges that

lie ahead, and identify major avenues for health systems to narrow the intolerable gaps between aspiration and implementation.

These avenues are defined in the Report as four sets of reforms that reflect a convergence between the values of primary health care, the expectations of citizens and the common health performance challenges that cut across all contexts. They include:

- *universal coverage reforms* that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection;
- *service delivery reforms* that re-organize health services around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world, while producing better outcomes;
- *public policy reforms* that secure healthier communities, by integrating public health actions with primary care, by pursuing healthy public policies across sectors and by strengthening national and transnational public health interventions; and
- *leadership reforms* that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership indicated by the complexity of contemporary health systems.

While universally applicable, these reforms do not constitute a blueprint or a manifesto for action. The details required to give them life in each country must be driven by specific conditions and contexts, drawing on the best available evidence. Nevertheless, there are no reasons why any country – rich or poor – should wait to begin moving forward with these reforms. As the last three decades have demonstrated, substantial progress is possible.

Doing better in the next 30 years means that we need to invest now in our ability to bring actual performance in line with our aspirations, expectations and the rapidly changing realities of our interdependent health world. United by the common challenge of primary health care, the time is ripe, now more than ever, to foster joint learning and sharing across nations to chart the most direct course towards health for all.

Dr Margaret Chan
Director-General
World Health Organization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Introduction and Overview

Why a renewal of primary health care (PHC), and why now, more than ever? The immediate answer is the palpable demand for it from Member States – not just from health professionals, but from the political arena as well.

Globalization is putting the social cohesion of many countries under stress, and health systems, as key constituents of the architecture of contemporary societies, are clearly not performing as well as they could and as they should.

People are increasingly impatient with the inability of health services to deliver levels of national coverage that meet stated demands and changing needs, and with their failure to provide services in ways that correspond to their expectations. Few would disagree that health systems need to respond better – and faster – to the challenges of a changing world. PHC can do that.

There is today a recognition that populations are left behind and a sense of lost opportunities that are reminiscent of what gave rise, thirty years ago, to Alma-Ata's paradigm shift in thinking about health. The Alma-Ata Conference mobilized a "Primary Health Care movement" of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the "*politically, socially and economically unacceptable*"[1] health inequalities in all countries. The Declaration of Alma-Ata was clear about the values pursued: social justice and the right to better health for all, participation and solidarity[1]. There was a sense that progress towards these values required fundamental changes in the way health-care systems operated and harnessed the potential of other sectors.

The translation of these values into tangible reforms has been uneven. Nevertheless, today, health equity enjoys increased prominence in the discourse of political leaders and ministries of health[2], as well as of local government structures, professional organizations and civil society organizations.

The PHC values to achieve health for all require health systems that: *"Put people at the centre of health care"*[3]. What people consider desirable ways of living as individuals and what they expect for their societies – i.e. what people value – constitute important parameters for governing the health sector. PHC has remained the benchmark for most countries' discourse on health precisely because the PHC movement tried to provide rational, evidence-based and anticipatory responses to health needs *and* to these social expectations[4,5,6,7]. Achieving this requires trade-offs that must start by taking into account citizens' *"expectations about health and health care"* and ensuring *"that [their] voice and choice decisively influence the way in which health services are designed and operate"*[8]. A recent PHC review echoes this perspective as the *"right to the highest attainable level of health"*, *"maximizing equity and solidarity"* while being guided by *"responsiveness to people's needs"*[4]. Moving towards health for all requires that health systems respond to the challenges of a changing world and growing expectations for better performance. This involves substantial reorientation and reform of the ways health systems operate in society today: those reforms constitute the agenda of the renewal of PHC.

Responding to the challenges of a changing world

On the whole, people are healthier, wealthier and live longer today than 30 years ago. If children were still dying at 1978 rates, there would have been 16.2 million deaths globally in 2006. In fact, there were only 9.5 million such deaths[9]. This difference of 6.7 million is equivalent to 18 329 children's lives being saved every day. The once revolutionary notion of essential drugs has become commonplace. There have been significant improvements in access to water, sanitation and antenatal care.

This shows that progress is possible. It can also be accelerated. There have never been more resources available for health than now. The global health economy is growing faster than gross domestic product (GDP), having increased its share from 8% to 8.6% of the world's GDP between 2000 and 2005. In absolute terms, adjusted for inflation, this represents a 35% growth in the world's expenditure on health over a five-year period. Knowledge and understanding of health are growing rapidly. The accelerated technological revolution is multiplying the potential for improving health and transforming health literacy in a better-educated and modernizing global society. A global stewardship is emerging: from intensified exchanges between countries, often in recognition of shared threats, challenges or opportunities; from growing solidarity; and from the global commitment to eliminate poverty exemplified in the Millennium Development Goals (MDGs).

However, there are other trends that must not be ignored. First, the substantial progress in health over recent decades has been deeply unequal, with convergence towards improved health in a large part of the world, but at the same time, with a considerable number of countries increasingly lagging behind or losing ground. Furthermore, there is now ample documentation – not available 30 years ago – of considerable and often growing health inequalities within countries.

Second, the nature of health problems is changing in ways that were only partially anticipated, and at a rate that was wholly unexpected. Ageing and the effects of ill-managed urbanization and globalization accelerate worldwide transmission of communicable diseases, and increase the burden of chronic and noncommunicable disorders. The growing reality that many individuals present with complex symptoms and multiple illnesses challenges service delivery to develop more integrated and comprehensive case management. A complex web of interrelated factors is at work, involving gradual but long-term increases in income and population, climate change, challenges to food security, and social tensions, all with definite, but largely unpredictable, implications for health in the years ahead.

Third, health systems are not insulated from the rapid pace of change and transformation that is an essential part of today's globalization. Economic and political crises challenge state and institutional roles to ensure access, delivery and financing. Unregulated commercialization is accompanied by a blurring of the boundaries between public and private actors, while the negotiation of entitlement and rights is increasingly politicized. The information age has transformed the relations between citizens, professionals and politicians.

In many regards, the responses of the health sector to the changing world have been inadequate and naïve. Inadequate, insofar as they not only fail to anticipate, but also to respond appropriately: too often with too little, too late or too much in the wrong place. Naïve insofar as a system's failure requires a system's solution – not a temporary remedy. Problems with human resources for public health and health care, finance, infrastructure or information systems invariably extend beyond the narrowly defined health sector, beyond a single level of policy purview and, increasingly, across borders: this raises the benchmark in terms of working effectively across government and stakeholders.

While the health sector remains massively under-resourced in far too many countries, the resource base for health has been growing consistently over the last decade. The opportunities this growth offers for inducing structural changes and making health systems more effective and equitable are often missed. Global and, increasingly, national policy formulation processes have focused on single issues, with various constituencies competing for scarce resources, while scant attention is given to the underlying constraints that hold up health systems development in national contexts. Rather than improving their response capacity and anticipating new challenges, health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear sense of direction.

Today, it is clear that left to their own devices, health systems do not gravitate naturally towards the goals of health for all through primary health care as articulated in the Declaration of Alma-Ata. Health systems are developing in directions that contribute little to equity and social justice and fail to get the best health outcomes for their money. Three particularly worrisome trends can be characterized as follows:

- health systems that focus disproportionately on a narrow offer of specialized curative care;
- health systems where a command and control approach to disease control, focused on short-term results, is fragmenting service delivery;
- health systems where a hands-off or laissez-faire approach to governance has allowed unregulated commercialization of health to flourish.

These trends fly in the face of a comprehensive and balanced response to health needs. In a number of countries, the resulting inequitable access, impoverishing costs, and erosion of trust in health care constitute a threat to social stability.

Growing expectations for better performance

The support for a renewal of PHC stems from the growing realization among health policy-makers, that it can provide a stronger sense of direction and unity in the current context of fragmentation of health systems, and an alternative to the assorted quick fixes currently touted as cures for the health sector's ills. There is also a growing realization that conventional health-care

delivery, through different mechanisms and for different reasons, is not only less effective than it could be, but suffers from a set of ubiquitous shortcomings and contradictions that are summarized in Box 1.

The mismatch between expectations and performance is a cause of concern for health authorities. Given the growing economic weight and social significance of the health sector, it is also an increasing cause for concern among politicians: it is telling that health-care issues were, on average, mentioned more than 28 times in each of the recent primary election debates in the United States[22]. Business as usual for health systems is not a viable option. If these shortfalls in performance are to be redressed, the health problems of today and tomorrow will require stronger collective management and accountability guided by a clearer sense of overall direction and purpose.

Indeed, this is what people expect to happen. As societies modernize, people demand more from their health systems, for themselves and their families, as well as for the society in which they live. Thus, there is increasingly popular support for better health equity and an end to exclusion; for health services that are centred on people's needs and expectations; for health security for the communities in which they live; and for a say in what affects their health and that of their communities[23].

These expectations resonate with the values that were at the core of the Declaration of Alma-Ata. They explain the current demand for a better alignment of health systems with these values and provide today's PHC movement with reinvigorated social and political backing for its attempts to reform health systems.

Box 1 Five common shortcomings of health-care delivery

Inverse care. People with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least[10]. Public spending on health services most often benefits the rich more than the poor[11] in high- and low-income countries alike[12,13].

Impoverishing care. Wherever people lack social protection and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses. Over 100 million people annually fall into poverty because they have to pay for health care[14].

Fragmented and fragmenting care. The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care[15]. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced[16], while development aid often adds to the fragmentation[17].

Unsafe care. Poor system design that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections, along with medication errors and other avoidable adverse effects that are an underestimated cause of death and ill-health[18].

Misdirected care. Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden[19,20]. At the same time, the health sector lacks the expertise to mitigate the adverse effects on health from other sectors and make the most of what these other sectors can contribute to health[21].

From the packages of the past to the reforms of the future

Rising expectations and broad support for the vision set forth in Alma-Ata's values have not always easily translated into effective transformation of health systems. There have been circumstances and trends from beyond the health sector – structural adjustment, for example – over which the PHC movement had little influence or control. Furthermore, all too often, the PHC movement has oversimplified its message, resulting in one-size-fits-all recipes, ill-adapted to different contexts and problems[24]. As a result, national and global health authorities have at times seen PHC not as a set of reforms, as was intended, but as one health-care delivery programme among many, providing poor care for poor people. Table 1 looks at different dimensions of early attempts at implementing PHC and contrasts this with current approaches. Inherent in this evolution is recognition that providing a sense of direction to health systems requires a set of specific and context-sensitive reforms that respond to the health challenges of today and prepare for those of tomorrow.

The focus of these reforms goes well beyond "basic" service delivery and cuts across the established boundaries of the building blocks of national health systems[25]. For example, aligning health systems based on the values that drive PHC will require ambitious human resources policies. However, it would be an illusion to think that these can be developed in isolation from financing or service delivery policies, civil service reform and arrangements dealing with the cross-border migration of health professionals.

At the same time, PHC reforms, and the PHC movement that promotes them, have to be more responsive to social change and rising expectations that come with development and modernization. People all over the world are becoming more vocal about health as an integral part of how they and their families go about their everyday lives, and about the way their society deals with health and health care. The dynamics of demand must find a voice within the policy and decision-making processes. The necessary reorientation of health systems has to be based on sound scientific evidence and on rational management of uncertainty, but it should also integrate what people expect of health and health care for themselves, their families and their society. This requires delicate trade-offs and negotiation with multiple stakeholders that imply a stark departure from the linear, top-down models of the past. Thus, PHC reforms today are neither primarily defined by the component elements they address, nor merely by the choice of disease control interventions to be scaled up, but by the social dynamics that define the role of health systems in society.

Table 1 How experience has shifted the focus of the PHC movement

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT CONCERNS OF PHC REFORMS
Extended access to a basic package of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
Concentration on mother and child health	Dealing with the health of everyone in the community
Focus on a small number of selected diseases, primarily infectious and acute	A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses
Improvement of hygiene, water, sanitation and health education at village level	Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards
Simple technology for volunteer, non-professional community health workers	Teams of health workers facilitating access to and appropriate use of technology and medicines
Participation as the mobilization of local resources and health-centre management through local health committees	Institutionalized participation of civil society in policy dialogue and accountability mechanisms
Government-funded and delivered services with a centralized top-down management	Pluralistic health systems operating in a globalized context
Management of growing scarcity and downsizing	Guiding the growth of resources for health towards universal coverage
Bilateral aid and technical assistance	Global solidarity and joint learning
Primary care as the antithesis of the hospital	Primary care as coordinator of a comprehensive response at all levels
PHC is cheap and requires only a modest investment	PHC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives

Four sets of PHC reforms

This report structures the PHC reforms in four groups that reflect the convergence between the evidence on what is needed for an effective response to the health challenges of today's world, the values of equity, solidarity and social justice that drive the PHC movement, and the growing expectations of the population in modernizing societies (Figure 1):

- reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection – *universal coverage reforms*;
- reforms that reorganize health services as primary care, i.e. around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world while producing better outcomes – *service delivery reforms*;
- reforms that secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors – *public policy reforms*;
- reforms that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership required by the complexity of contemporary health systems – *leadership reforms*.

The first of these four sets of reforms aims at diminishing exclusion and social disparities in health. Ultimately, the determinants of health inequality require a societal response, with political and technical choices that affect many different sectors. Health inequalities are also shaped by the inequalities in availability, access and quality of services, by the financial burden these impose on people, and even by the linguistic, cultural and gender-based barriers that are often embedded in the way in which clinical practice is conducted[26].

If health systems are to reduce health inequities, a precondition is to make services available to all, i.e. to bridge the gap in the supply of services. Service networks are much more extensive today than they were 30 years ago, but large population groups have been left behind. In some places, war and civil strife have destroyed infrastructure, in others, unregulated commercialization has made services available, but not necessarily those that are needed. Supply gaps are still a reality in many countries, making extension of their service networks a priority concern, as was the case 30 years ago.

Figure 1 The PHC reforms necessary to refocus health systems towards health for all

As the overall supply of health services has improved, it has become more obvious that barriers to access are important factors of inequity: user fees, in particular, are important sources of exclusion from needed care. Moreover, when people have to purchase health care at a price that is beyond their means, a health problem can quickly precipitate them into poverty or bankruptcy[14]. That is why extension of the supply of services has to go hand-in-hand with social health protection, through pooling and pre-payment instead of out-of-pocket payment of user fees. The reforms to bring about universal coverage – i.e. universal access combined with social health protection – constitute a necessary condition to improved health equity. As systems that have achieved near universal coverage show, such reforms need to be complemented with another set of proactive measures to reach the unreached: those for whom service availability and social protection

does too little to offset the health consequences of social stratification. Many individuals in this group rely on health-care networks that assume the responsibility for the health of entire communities. This is where a second set of reforms, the service delivery reforms, comes in.

These service delivery reforms are meant to transform conventional health-care delivery into primary care, optimizing the contribution of health services – local health systems, health-care networks, health districts – to health and equity while responding to the growing expectations for *"putting people at the centre of health care, harmonizing mind and body, people and systems"*[3]. These service delivery reforms are but one subset of PHC reforms, but one with such a high profile that it has often masked the broader PHC agenda. The resulting confusion has been compounded by the oversimplification of what primary care entails and of what distinguishes it from conventional health-care delivery (Box 2)[24].

There is a substantial body of evidence on the comparative advantages, in terms of effectiveness and efficiency, of health care organized as people-centred primary care. Despite variations in the specific terminology, its characteristic features (person-centredness, comprehensiveness and integration, continuity of care, and participation of patients, families and communities) are well identified[15,27]. Care that exhibits these features requires health services that are organized accordingly, with close-to-client multidisciplinary teams that are responsible for a defined population, collaborate with social services and other sectors, and coordinate the contributions of hospitals, specialists and community organizations. Recent economic growth has brought additional resources to health. Combined with the growing demand for better performance, this creates major opportunities to reorient existing health services towards primary care – not only in well-resourced settings, but also where money is tight and needs are high. In the many low- and middle-income countries where the supply of services is in a phase of accelerated expansion, there is an opportunity now to chart a course that may avoid repeating some of the mistakes high-income countries have made in the past.

Primary care can do much to improve the health of communities, but it is not sufficient to respond to people's desires to live in conditions that protect their health, support health equity

Box 2 What has been considered primary care in well-resourced contexts has been dangerously oversimplified in resource-constrained settings

Primary care has been defined, described and studied extensively in well-resourced contexts, often with reference to physicians with a specialization in family medicine or general practice. These descriptions provide a far more ambitious agenda than the unacceptably restrictive and off-putting primary-care recipes that have been touted for low-income countries[27,28]:

- primary care provides a place to which people can bring a wide range of health problems – it is not acceptable that in low-income countries primary care would only deal with a few "priority diseases";
- primary care is a hub from which patients are guided through the health system – it is not acceptable that, in low-income countries, primary care would be reduced to a stand-alone health post or isolated community-health worker;
- primary care facilitates ongoing relationships between patients and clinicians, within which patients participate in decision-making about their health and health care; it builds bridges between personal health care and patients' families and communities – it is not acceptable that, in low-income countries, primary care would be restricted to a one-way delivery channel for priority health interventions;
- primary care opens opportunities for disease prevention and health promotion as well as early detection of disease – it is not acceptable that, in low-income countries, primary care would just be about treating common ailments;
- primary care requires teams of health professionals: physicians, nurse practitioners, and assistants with specific and sophisticated biomedical and social skills – it is not acceptable that, in low-income countries, primary care would be synonymous with low-tech, non-professional care for the rural poor who cannot afford any better;
- primary care requires adequate resources and investment, and can then provide much better value for money than its alternatives – it is not acceptable that, in low-income countries, primary care would have to be financed through out-of-pocket payments on the erroneous assumption that it is cheap and the poor should be able to afford it.

and enable them to lead the lives that they value. People also expect their governments to put into place an array of public policies to deal with health challenges, such as those posed by urbanization, climate change, gender discrimination or social stratification.

These public policies encompass the technical policies and programmes dealing with priority health problems. These programmes can be designed to work through, support and give a boost to primary care, or they can neglect to do this and, however unwillingly, undermine efforts to reform service delivery. Health authorities have a major responsibility to make the right design decisions. Programmes to target priority health problems through primary care need to be complemented by public health interventions at national or international level. These may offer scale efficiencies; for some problems, they may be the only workable option. The evidence is overwhelming that action on that scale, for selected interventions, which may range from public hygiene and disease prevention to health promotion, can have a major contribution to health. Yet, they are surprisingly neglected, across all countries, regardless of income level. This is particularly visible at moments of crisis and acute threats to the public's health, when rapid response capacity is essential not only to secure health, but also to maintain the public trust in the health system.

Public policy-making, however, is about more than classical public health. Primary care and social protection reforms critically depend on choosing health-systems policies, such as those related to essential drugs, technology, human resources and financing, which are supportive of the reforms that promote equity and people-centred care. Furthermore, it is clear that population health can be improved through policies that are controlled by sectors other than health. School curricula, the industry's policy towards gender equality, the safety of food and consumer goods, or the transport of toxic waste are all issues that can profoundly influence or even determine the health of entire communities, positively or negatively, depending on what choices are made. With deliberate efforts towards intersectoral collaboration, it is possible to give due consideration to "health in all policies"[29] to ensure that, along with the other sectors' goals and objectives, health effects play a role in public policy decisions.

In order to bring about such reforms in the extraordinarily complex environment of the health sector, it will be necessary to reinvest in public leadership in a way that pursues collaborative models of policy dialogue with multiple stakeholders – because this is what people expect, and because this is what works best. Health authorities can do a much better job of formulating and implementing PHC reforms adapted to specific national contexts and constraints if the mobilization around PHC is informed by the lessons of past successes and failures. The governance of health is a major challenge for ministries of health and the other institutions, governmental and nongovernmental, that provide health leadership. They can no longer be content with mere administration of the system: they have to become learning organizations. This requires inclusive leadership that engages with a variety of stakeholders beyond the boundaries of the public sector, from clinicians to civil society, and from communities to researchers and academia. Strategic areas for investment to improve the capacity of health authorities to lead PHC reforms include making health information systems instrumental to reform; harnessing the innovations in the health sector and the related dynamics in all societies; and building capacity through exchange and exposure to the experience of others – within and across borders.

Seizing opportunities

These four sets of PHC reforms are driven by shared values that enjoy large support and challenges that are common to a globalizing world. Yet, the starkly different realities faced by individual countries must inform the way they are taken forward. The operationalization of universal coverage, service delivery, public policy and leadership reforms cannot be implemented as a blueprint or as a standardized package.

In high-expenditure health economies, which is the case of most high-income countries, there is ample financial room to accelerate the shift from tertiary to primary care, create a healthier policy

environment and complement a well-established universal coverage system with targeted measures to reduce exclusion. In the large number of fast-growing health economies – which is where 3 billion people live – that very growth provides opportunities to base health systems on sound primary care and universal coverage principles at a stage where it is in full expansion, avoiding the errors by omission, such as failing to invest in healthy public policies, and by commission, such as investing disproportionately in tertiary care, that have characterized health systems in high-income countries in the recent past. The challenge is, admittedly, more daunting for the 2 billion people living in the low-growth health economies of Africa and South-East Asia, as well as for the more than 500 million who live in fragile states. Yet, even here, there are signs of growth – and evidence of a potential to accelerate it through other means than through the counterproductive reliance on inequitable out-of-pocket payments at points of delivery – that offer possibilities to expand health systems and services. Indeed, more than in other countries, they cannot afford not to opt for PHC and, as elsewhere, they can start doing so right away.

The current international environment is favourable to a renewal of PHC. Global health is receiving unprecedented attention, with growing interest in united action, greater calls for comprehensive and universal care – be it from people living with HIV and those concerned with providing treatment and care, ministers of health, or the Group of Eight (G8) – and a mushrooming of innovative global funding mechanisms related to global solidarity. There are clear and welcome signs of a desire to work together in building sustainable systems for health rather than relying on fragmented and piecemeal approaches[30].

At the same time, there is a perspective of enhanced domestic investment in re-invigorating the health systems around PHC values. The growth in GDP – admittedly vulnerable to economic slowdown, food and energy crises and global warming – is fuelling health spending throughout the world, with the notable exception of fragile states. Harnessing this economic growth would offer opportunities to effectuate necessary PHC reforms that were unavailable during the 1980s and 1990s. Only a fraction of health spending currently goes to correcting common distortions in the way health systems function or to overcoming system bottlenecks that constrain service delivery, but the potential is there and is growing fast.

Global solidarity – and aid – will remain important to supplement and suppport countries making slow progress, but it will become less important per se than exchange, joint learning and global governance. This transition has already taken place in most of the world: most developing countries are *not* aid-dependent. International cooperation can accelerate the conversion of the world's health systems, including through better channelling of aid, but real progress will come from better health governance in countries – low- and high-income alike.

The health authorities and political leaders are ill at ease with current trends in the development of health systems and with the obvious need to adapt to the changing health challenges, demands and rising expectations. This is shaping the current opportunity to implement PHC reforms. People's frustration and pressure for different, more equitable health care and for better health protection for society is building up: never before have expectations been so high about what health authorities and, specifically, ministries of health should be doing about this.

By capitalizing on this momentum, investment in PHC reforms can accelerate the transformation of health systems so as to yield better and more equitably distributed health outcomes. The world has better technology and better information to allow it to maximize the return on transforming the functioning of health systems. Growing civil society involvement in health and scale-efficient collective global thinking (for example, in essential drugs) further contributes to the chances of success.

During the last decade, the global community started to deal with poverty and inequality across the world in a much more systematic way – by setting the MDGs and bringing the issue of inequality to the core of social policy-making. Throughout, health has been a central, closely interlinked concern. This offers opportunities for more effective health action. It also creates the necessary social conditions for the establishment

of close alliances beyond the health sector. Thus, intersectoral action is back on centre stage. Many among today's health authorities no longer see their responsibility for health as being limited to survival and disease control, but as one of the key capabilities people and societies value[31].

The legitimacy of health authorities increasingly depends on how well they assume responsibility to develop and reform the health sector according to what people value – in terms of health and of what is expected of health systems in society.

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