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Commentary – Alma Ata

The enduring legacy of Alma Ata: 30 years on

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ABSTRACT

The 1978 Alma Ata conference and declaration was a landmark in defining and providing a direction for primary healthcare. Despite the initial enthusiasm for Alma Ata, its impact appeared to have declined in the 1990s. However, in recent years, there has been a revitalisation of primary healthcare. This article reviews the Alma Ata conference and declaration, assesses its waxing and waning, and examines its recent revival. The paper draws conclusions about the relevance of Alma Ata, 30 years on.

Keywords: Alma Ata, implementation, primary healthcare

2008: a time to remember

2008 appears to be a year for anniversaries in the UK, at least in terms of health policy. Not only is 2008 the 60th anniversary of the inception of the NHS but it also marks 25 years since the publication of the Griffiths Inquiry report (which introduced general management into the NHS) and 10 years since the publication of the Acheson Inquiry into health inequalities (which has influenced government policy on the social determinants of health).

Such commemorations are not confined to the UK alone. One which has not enjoyed a great deal of attention this year is the 30th anniversary of the Alma Ata conference and declaration which was a major milestone in the late 20th century and forged a new direction for primary healthcare across the world.[1]

This article traces the origins and aims of the Alma Ata declaration and explores its impact. Given the World Health Organization is seeking to 'revitalise' primary healthcare in 2008, the article also assesses why it apparently disappeared and why it is now back on the agenda.

1978 and all that

It is worth remembering the context of the 1970s which faced policy-makers and practitioners. The 1973 oil price crisis and the resulting 'new economic order' threw into sharp relief the gross inequalities across the world. (The context of the 1970s bears worrying similarities with 2008). This context precipitated a series of social reforms including the health sector, one of which arose from the Alma Ata conference in September 1978.

The International Conference on Primary Health Care (PHC) was held in Alma Ata (the former capital of Kazakhstan and now known as Almaty) and brought together 134 countries and 67 international organisations. It was organised by the World Health Organization (WHO) and UNICEF.

The conference culminated in the issue of a declaration which defined and gave international recognition to the concept of PHC. The conference was significant in its definition of and proposed strategy for PHC.

The definition of PHC which emerged from the conference is now widely adopted:

> Health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.

This definition is significant as it advances a social model of health (as opposed to a purely bio-medical one).[2] Moreover, the Alma Ata conference declared that health is a fundamental human right and that the attainment of the highest possible level of health is an important global social goal which requires the action of many other social and economic sectors, not simply the health sector. This recognition has become crucial in establishing a broad spectrum of support for policy to address the social determinants of health in more recent years.

Alma-Ata also asserted that PHC is 'the first level of contact of individuals, the family and community with the national health system bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process'.

The conference and declaration gave recognition to the strategy of PHC and efforts to reach the goal of 'Health for All 2000'. Ten statements underpinned this strategy:

1 health is a state of complete physical, mental and social wellbeing, and not just the absence of disease
2 gross inequality exists in the health status of the people particularly between developed and developing countries, and within these countries
3 economic and social development is vital to the fullest attainment of health for all and to the reduction of health inequalities
4 individuals have a right and duty to participate individually and collectively in the planning and implementation of their healthcare
5 'governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures'
6 'primary healthcare is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community 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'
7 primary healthcare must recognise national socioeconomic and political context, and must address key health problems
8 all governments should formulate national policies ensure that primary healthcare forms part of a comprehensive national health system
9 countries should work in collaboration to foster primary healthcare
10 'an acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources'. www.euro.who.int/AboutWHO/Policy/20010827_1

In short, the Alma Ata conference and declaration put PHC on the agenda of policy-makers and practitioners across the world. In doing so, it provided a framework for action in terms of access to care, equity, promotion and participation.

Implementing Alma Ata

Alma Ata (its short-hand description of the conference and declaration denoting its powerful influence) prompted a series of policy programmes and initiatives from WHO and national governments, over the years that followed. These addressed primary care development, health for all strategies and social determinants of health (including health inequalities). Such a shift in the direction and scope in health systems is a major achievement that others have been unable to replicate. For example, earlier this year, Halfdan Mahler (former Director-General of WHO) claimed that:

> '...the Alma-Ata primary healthcare consensus has had major inspirational and operational impacts in many countries [which have] a critical mass of political and professional leadership combined with adequate human and financial resources to test its adaptability and applicability within the local realities' (www.socialmedicine.org/2008/06/11/globalization-and-health/former-who-director-halfdan-mahler-on-alma-ata-phc-may-2008/)

However, despite this apparent success in achieving recognition of the importance of PHC and with the benefit of 30 years of hindsight, a number of shortcomings in its implementation have become manifested. Indeed, the People's Health movement claims that Alma Ata was 'never really implemented' (www.phmovement.org/cms/en/node/588). This has generated a degree of disappointment at the lost opportunities for implementing Alma Ata, whether in the spirit or the letter of the declaration. Why might this pessimism have arisen given the high hopes of 30 years ago? The answer may lie in a combination of the following explanations.

Implementation

First, as with other major policy programmes, the rhetoric has been comparatively easy compared to the implementation. Whilst Alma Ata generated a broad appeal, both geographically across the world and across disciplines, many health systems failed to reorient themselves towards PHC. Some of the implementation failure can be explained by the competing imperatives, including:

- the dominant focus on acute (hospital) care in most countries (founded on the bio-medical model of health)
- structural adjustment programmes in developing countries (fostered by the World Bank)
- the global spread of privatisation
- the inimical effects of globalisation.

Other aspects of this failure include an inability to make sufficient headway in each of the pillars of Alma Ata: participation, equity and inter-sectoral collaboration. To illustrate the first of these, Peckham and Exworthy[2] argue that documents published by the WHO and others acknowledge that:

> '...people's participation in any meaningful form is difficult for health workers in general and almost inevitably runs into problems arising from both the attitudes of these workers and the structures of healthcare systems.'

Lost interest?

Second, in the light of the implementation dilemmas (above), PHC was been relegated in agendas of policymakers and some practitioners. Such a decline, Halfdan Mahler argues, is explained by a loss of interest or a distortion of the Alma Ata message. PHC was redefined in the interests of international agencies and donors. Two key and related developments might explain such a 'distortion': marketisation and structural adjustment programmes.

Marketisation was a process which sought to introduce market-style relations, mechanisms and incentives in many health systems in the 1990s. The principal reform was the introduction of purchasers and providers, mediated by contractual relations and monetary exchange. As all countries' health systems involve some government intervention, marketisation was heavily regulated; hence the managed or internal market. Markets relied on products/services which could be easily defined, specified and measured. The emphasis of such markets was in secondary/acute care. Though PHC was often used as a lever of change over secondary (note the GP fund-holding system in England) in the quasi-markets,[2] the development of PHC (and its related components such as participation and equity) was largely neglected in this period. The experiment in quasi-markets since the 1990s has not so much run its course but has been re-defined and packaged, with greater attention on PHC; note, for example, the transition from GP fund-holding to practice-based commissioning in England. However, difficulties still remain in applying market to PHC.

Structural adjustment programmes, promulgated by the World Bank and others, represented the opportunity for international institutions to forge a new economic order in the 1980s and 1990s by spreading a neo-liberal agenda of public sector reform. Invariably, this involved marketisation, reductions in public expenditure and greater involvement of the private sector in public services. As a result of the narrowly-defined programmes and their prescriptions, the idealism of Alma Ata was dissipated. Mahler lamented this decline:

> 'How sad that some 30 years later, this expansive vision of health founded on primary care and social change has been replaced by the miserly and narrow-minded ''Millennium Development Goals'' '(ibid)

Yet, achieving the MDGs also appears to be fraught with difficulty, as Margaret Chan (current Director-General of WHO) recently argued:

> 'Progress in meeting the health-related Millennium Development Goals has stalled. In fact, of all the goals, those pertaining directly to health are the least likely to be met' (www.who.int/dg/speeches/2007/20071101_beijing/en/index.html)

The 'revitalisation' of PHC

The 30 years since the Alma Ata conference and declaration has seen the waxing and waning of PHC. However, in recent years and especially in the last 12 months, there has been a revived interest in PHC. Though some might question whether it ever went away (and if so, why), it is also important to understand the reasons for the renewed interest in it in recent times. Why is PHC apparently back in favour? Some of the answers seem to lie in the reasons for its previous demise.

First, it is significant that Dr Margaret Chan used her opening address (in November 2006) as the new Director-General of WHO to call for 'a return to primary health care as an approach for strengthening health systems' (www.who.int/dg/speeches/2007/20071101_ beijing/en/index.html; November 2007). Such leadership provides an impetus for national and local efforts.

Second, the social determinants of health (SDH) have assumed much greater prominence in the last few years, not least because of the WHO Commission on Social Determinants of Health (chaired by Professor Sir Michael Marmot of UCL) (www.who.int/social_determinants/en/). The Commission was launched in 2005, with a brief 'to provide evidence on policies that improve health by addressing the social conditions which people live and work, and to collaborate with countries to support policy change and monitor results'. Its remit is global but has also focused on case-study work in specific countries such as Brazil, Chile, Iran and Kenya. It completes its work in 2008. Evidence from the WHO Commission (and others) has helped to highlight the scale and complexity of the challenges associated with SDH. For example, 'a child born in Japan has a chance of living 43 years longer than a child born in Sierra Leone' (www.who.int/features/factfiles/sdh/02_en.html). The work on SDH has helped to shape the context in which PHC is being reconsidered because SDH share many of the same tenets as PHC – participation, equity and inter-sectoral

collaboration, for example. It is vital the SDH becomes integrated into health systems if it is not to suffer the same fate as similar initiatives such as 'health for all 2000.'

Third, the process of economic globalisation has had consequences in terms of health and healthcare. Much attention is focused on 'health as a foreign policy' issue. This has been especially in terms of migration and disease prevention programmes (such as Avian flu and HIV/AIDS) but equally, in terms of social-economic development and poverty reduction. Moreover, progress in reaching the health-related Millennium Development Goals appears to have 'stalled', according to Margaret Chan but she is 'convinced' that these goals can be achieved with 'a return to the values, principles, and approaches of primary healthcare'.

PHC in the next 30 years

Global developments in PHC may seem to have little (or limited) relevance to London. However, the principles of Alma Ata are still highly significant in a context of the Darzi Review, practice-based commissioning and foundation trusts (to name but a few). Participation and inter-sectoral action are vital to the achievement not only of these healthcare imperatives but also to the wider health system including the social determinants of health and prevention.[3]

Why is PHC well placed to achieve healthcare reform and health improvement (especially amongst those in greatest need)? Starfield[4,5] has demonstrated, across many countries, that a health system oriented around PHC is both highly efficient and effective. It generates better health outcomes, at lower costs and with high user satisfaction.

The testament of Alma Ata has been not only to reshape health systems across the world but to provide a justification and route-map to achieving better health, more equitably, more participatively and more collaboratively. The challenges of implementing the PHC vision, however, remain as profound as ever. There needs to be a determined and widespread commitment to the principles of Alma Ata. As Halfdan Mahler declares, there needs to be 'a courageous adhesion to its health message of equity in local and global health'. This is the challenge for PHC for the next 30 years.

CONFLICTS OF INTEREST

The author was a member of the WHO Commission on Social Determinants of Health (2005–2008).

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