

Health for All Now!

Reviving the spirit of Alma Ata in the twenty-first century:

An Introduction to the Alma Ata Declaration

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Abstract

In 1978 two United Nations organizations, the World Health Organization and UNICEF, held a joint conference at Alma Ata in the Soviet Union at which health was described as a human right to which all people were entitled. The goal of achieving health for all by the end of the century was established. The Alma Ata Declaration on Primary Health Care emerged from this conference. It was endorsed on the 12th September 1978, and has inspired subsequent generations of health activists. It has become a common meeting ground where likeminded public health personnel can compare and discuss strategy and relate their discussion to a common document. The slogan “Health for All by the Year 2000”, while not achieved, has been a rallying call for progressive health workers and activists. The Declaration has also inspired the global people’s health movement and two global people’s health assemblies. The concept “primary health care” has been crucial to the improvement of many countries’ health systems and, while its meaning has been variously interpreted, the pursuit of the ideal of comprehensive primary health care still motivates health workers around the world who want to ensure a more people-centered, responsive and effective and efficient health care system for their community and country. Thus the Alma Ata Declaration is a quite remarkable document and has made an impact that few other before or since have had.

This article describes the international context that enabled the drafting and adoption of the Alma Ata Declaration. It then describes the document and assesses the reasons for its importance. The struggles for the ideals and strategies of the Declaration through the progressively more hostile international climate of the 1980s and 1990s are discussed. Finally, the prospects for a revival of the spirit of Alma Ata are assessed.

Long tradition of grassroots action

The Alma Ata Declaration emerged after two decades in which medicine had made significant advances through vaccines and chemotherapies for infectious diseases. Yet the technical solutions were not enough and the challenge of providing equal access for the entire world’s population remained. In the 1960s and 1970s examples such as the barefoot doctors in China and the Mexican health worker program inspired by David Werner¹, the Jamkhed program in India² and grassroots movement in Latin America showed that if there was adequate political will then, at affordable cost, the technology available was sufficient to achieve significant improvement in health. Between 1973 and 1978 China with support from the Soviet Union and some African states worked to persuade WHO of the need for a more grassroots approach to health care that stressed primary health care and the social roots of illness³. It was lessons from grass roots initiatives such as these that informed the drafting of the Alma Ata document. The Declaration also drew on the historical legacy of social medicine and the work of nineteenth century activists such as Rudolf Virchow that was celebrated in the first edition of this journal⁴. The Alma Ata conference was jointly sponsored by WHO and UNICEF and the original Declaration was published under the

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logos of the two organizations⁵. It reflects the vision and inspirational leadership of the then Director General of WHO, Dr. Halfdan Mahler. The Declaration formed a significant break for WHO from its earlier reliance on a 'top-down' transfer of professional medical authority to solve the world's health problems⁶.

What does it say?

The Alma Ata Declaration was based on the following understandings:

- The importance of health as a fundamental human right that should be achieved through collective action by societies and is a responsibility of governments.
- The unacceptability of the "gross" inequities in health status especially those between poor and rich countries.
- The understanding that good health for all will advance social and economic development and world peace.
- The importance of people's participation in health care as both a right and duty.
- The recognition that primary health care should be universally accessible in a manner the community and country can afford and should bring health care as close as possible to where people live and work and should include "promotive, preventive, curative and rehabilitative" services
- The recognition that achieving health for all will require coordinated effort from all sectors that have an impact on health
- The realization that its implementation will require political will to mobilize resources for PHC.
- The acceptance of the inter-dependence between countries and that the "attainment of health by people in anyone country directly concerns and benefits every other country.
- The recognition that armaments and military conflicts take away resources from achieving health for all and that peace and disarmament will release resources for social and economic development

The Document is inspirational and visionary. Its tone is one of hope and possibilities. It gives a sense of its aspirations being achievable and eminently sensible while also being idealistic. It

eschews a vision of health based on technical solutions alone and sees health as a technical, social and political issue. The Declaration is clear that social and economic development is entwined and that level of health affects both. By contrast the two major Commissions launched by WHO in the past decade have separated economic and social factors. Thus the Commission on Macroeconomics and Health⁷ looked as the importance of health as a means of encouraging economic development. Criticism of this single-minded focus of the Commission on Macroeconomics and Health is one of the reasons the Commission on the Social Determinants of Health was launched by WHO in 2005⁸. Reading the Alma Ata document suggests that the WHO that produced it would not have established two separate commissions but would have had one on the social and economic determinants of health. Re-reading the Alma Ata Declaration gives a sense that the economic and social aspects of life are not easily divisible in the ways that they have tended to become under neo-liberal economic policies.

Given the direction of health systems since 1978 it is important to consider what the Alma Ata Declaration did NOT say. Reading the document through twenty-first century eyes the Declaration is refreshingly free of statements about the need to change behaviors in order to promote health – the word behaviour doesn't make into the Declaration. It also conveys an impressive sense of the road to health as one paved with solidarity and collectivism rather than the ideology of individualism that has come to characterize so many debates about health since the 1970s. Thus while health is recognised as a "fundamental human right" it is also seen as a "worldwide social goal". The discourse of participation in the Declaration is one that echoes with images of citizens who have rights and duties. This contrasts strongly with the use of the term consumer that is being used in some health systems. "Consumer" is language borrowed from market ideologies and implies a person who is buying health services from a "producer" that is the health system⁹. This relationship tends to see human rights interpreted as the right to all the health services you can afford to buy. It does not imply the duty of citizens to make demands in terms of what is good

for the community as a whole as well as their own welfare.

The Alma Ata Declaration also does not address environmental issues and issues of sustainability. From an early 21st century vantage point this is an important absence. The problems that are clearly identified today such as the potential and actual health impacts of climate change, the depletion of non-renewable resources, especially oil the health problems of pollution and declining bio-diversity were not identified by WHO as pressing issues for primary health care in the late 1970s.

Watering down Alma Ata's Comprehensiveness

Within a year of the Alma Ata meeting the concept of selective primary health care was promulgated. Walsh and Warren¹⁰ (1979, 152) rationalized:

Until primary health care can be made available to all, services targeted to the few most important diseases may be the most effective means of improving the health of the greatest number of people. The crucial point is how to measure the effectiveness of medical interventions.

Their view immediately robbed primary health care of its community engagement, broader social change and re-distributive vision and placed it firmly back in the medical framework. MacDonald¹¹ notes that selective primary health care “is no threat or particular challenge to anyone; it suits the style and objectives of many donor agencies and fits well into the engineering model of health care”. He goes on to say that SPHC might be more accurately described as primary medical care. The issue of selectivity has not left the health policy agenda and the debates surrounding its value and impact have intensified in recent years. This has been in response to extensive investment in vertical health programs that focus on intervention in relation to one disease. The solutions tend to be technical and “evidence-based”. Critics note that this approach tends to fragment a health care system and take it away from the broader intersectoral and participatory approach. From a poor country perspective Banerji¹² describes the shift to selective primary health care as intellectual fascism” and notes that the evidence base for the

claims for the successes of selective approaches are not grounded in good science and that the approaches are profoundly ahistorical and do not build on local knowledge and experience. He cites the examples of Kerela State in India and Sri Lanka both of which have achieved remarkably good health outcomes despite the fact that they are low-income communities. Cuba is a further example, where, despite a far lower per capita income, life expectancy is not far behind rich countries such as the USA.

Selective primary health concerns its self with technical solutions to particular diseases such as malaria, tuberculosis, HIV/AIDS. By contrast, comprehensive primary health care starts with building a community infrastructure of accessible health centres staffed with well-trained health workers, based on community involvement, responsive to community definition of need and dedicated to building on community strengths and resilience. This infrastructure is designed to respond to the multiple and changing health needs faced by communities and is well-positioned to develop long lasting and effective links with other key sectors such as education, agriculture, housing and planning. Selective approaches, especially those imposed from outside, do not use local expertise or build the sustainability that more comprehensive approaches are able to do. Parallel selective approaches will lead to fragmentation, lack of co-ordination and drain main stream health systems of expertise and resources. In other words they will be less effective, inefficient and uncoordinated.

The key differences between selective and comprehensive PHC are shown in Table 1 (see next page). These differences demonstrate that the selective approach relies on medical interventions and professional control while the comprehensive approach rests on engagement with local communities, involvement of many sectors and dealing the underlying structural factors that threaten health. These differences make it clear why selective PHC may be more acceptable: it does not call into question existing power relationships or social organisation. By contrast empowering citizens and establishing health needs based on community perspectives and challenging medical hegemony is calling for a shift in power.

Table 1: The contrast between selective and comprehensive Primary Health Care

Characteristic	Selective	Comprehensive
Main aim	Reduction of specific disease – technical focus	Improvement in overall health of the community and individuals – and health for all as overall social and political goal
Sectors involved	Strong focus on health sector – very limited involvement from other sectors	Involvement of other sectors central
Strategies	Focus on curative care, with some attention to prevention and promotion	Comprehensive strategy with curative, rehabilitative, preventive and health promotion that seeks to remove root causes of health
Planning and strategy development	External, often ‘global’, programmes with little tailoring to local circumstances	Local and reflecting community priorities professional ‘on tap not on top’
Participation	Limited engagement, based on terms of outside experts and tending to be sporadic	Engaged participation that starts with community strengths and the community’s assessment of health issues, is ongoing and aims for community control
Engagement with politics	Professional and claims to be apolitical	Acknowledges that PHC is inevitably political and engages with local political structures
Forms of evidence	Limited to assessment of disease prevention strategy based on traditional epidemiological methods, usually conducted out of context and extrapolated to situation	Complex and varied research methods including epidemiology and qualitative and participatory methods

Source: Extended from Baum, F, ‘Primary health care: can the dream be revived?’, *Development in Practice*, Vol 13, No. 5. November 2003.

Sanders¹³ describes in detail the political struggles that underpin the improvement of health. In a latter co-authored work¹⁴ this struggle is further elaborated on through an analysis of the way in which oral re-hydration solution was advocated for by WHO and UNICEF and a strong case is made for comprehensive primary health care. UNICEF accepted the logic of the selective PHC argument when the organization adopted the GOBI (Growth Monitoring, Oral re-hydration Solution, Breastfeeding and Immunization) as the

priorities for improving the health of children and their mothers. The People’s Health Movement in India, Jam Swasthya Sabha¹⁵ comment of these selective strategies “instead of communities deciding their health priorities, as envisaged in the declaration, the priorities are set in a distant capital or at the World Bank and just thrust on the entire population”.

Perhaps one of the most fundamental issues associated with failure of countries to truly implement the message of the Alma Ata

Declaration is that, as Tejara de Rivero¹⁶ (a former Deputy Director General of WHO) has pointed out “For Mahler and others, “Health for All” was a social and political goal, but above all a battle cry to incite people to action. Its meaning, however, has been misunderstood, confused with a simple concept of programming that is technical rather than social and more bureaucratic than political”. But perhaps the true meaning of Alma Ata was understood all too well by those agencies who preferred the selective primary health care option that did not challenge existing power and authority and which left the way open for privatisation of health services in a way the implementation of the Mahler vision of primary health care would not. Tejara de Rivero also points out that —though it was spelled out clearly—it is rarely understood that health is, above all, “a complex social and political process that requires political decision-making not only at the sectorial level but also by the state, so that these decisions are binding upon all sectors without exception”. In other words primary health care is more than a commitment from the health sector it also a philosophy of equity and provision of the conditions for healthy living for all members of society.

It was also noticeable in the aftermath of Alma Ata that its messages were heard and in some cases taken up by countries in the developed world but that most developed countries saw primary health care as suitable for poor countries and not as having relevance to richer countries. What changed this to some extent was the launch of the Ottawa Charter in 1986¹⁷. This emerged from thinking in Canada and Europe and built very directly on the key understandings of Alma Ata. Its five key points have become a mantra for progressive health promoters. They are: the importance of building healthy public policy; the need to create supportive environments; the requirement for collective action; the importance of building personal skills so people can participate and protect and promote their own health and the need to re-orientate health systems. The path from Alma Ata to Ottawa was philosophically clear and both documents provide a basis for progressive health action. The call for Health for All was used by the community health movement in many countries. In the 1970s some rich countries like Canada and Australia developed particularly progressive community

health movements, which promoted health centres that attempted to put comprehensive PHC in to practice albeit against the tide of the mainstream health system¹⁸. Indigenous health movements also understood and had predated Alma Ata¹⁹. Self-determination and a realization of the central importance of the social determinants of health have been central to many of these struggles for health. For these groups the Alma Ata Declaration has been an important inspiration to keep up the struggle for health in what is often a hostile health system that has continued to privilege hospital care and continued to invest the overwhelming amount of its resources in to hospital based care.

Perhaps the most significant factor in the post Alma Ata environment was the shift in the political and economic climate. The launch of the Alma Ata Declaration coincided with a global economic crisis in the late 1970s and with a political shift to the right in a number of major industrialized countries. This set the scene for the introduction of Structural Adjustment Programs (SAPs) by the World Bank and the International Monetary Fund (IMF) as a condition for receiving bailout loans. These adjustment policies- which lowered real wages, reduced food subsidies, and slashed budgets for public health and education – harmed rather than benefited the health of poor people²⁰

A further crucial development in the 1990s was that WHO lost the unrivalled position as a leader in international public health. The publication of the World Bank’s report *Investing in Health* in 1993 saw the Bank become a major player. Its health prescription did not sit comfortably with Alma Ata. It considered which “investments” would be best for population health and its subsequent prescriptions advocated vertical disease focused solutions. Its broader project of imposing SAPs on poor countries has been widely seen as removing local control and greatly weakening the public sector infrastructure to the point where it is hard to see how health sectors in poor countries could lead the type of social change process envisaged by Alma Ata.

Thus the international climate had become hostile to the ideals of primary health care. Unfortunately WHO did not stick with the ideals espoused in the Alma Ata Declaration and in the late 1990s the headquarters of WHO comprehensively dropped the Alma Ata baton

with the exception of a sole publication, which did try to renew a focus on primary health care in the twenty-first century²¹. The Organisation focused more on vertical disease programs and engaged with the agenda of the World Bank. This was the period, which culminated with the formation of the Commission on Macroeconomic and Health. In the 1990s the WHO showed very little interest in developing earlier work on ways of making rhetoric about community participation meaningful. There were some exceptions. For instance the Global Program on Healthy Cities, originally initiated in the wake of the Ottawa Charter by the European office, worked directly with city governments and included in its guidelines a mandate to work closely communities. This movement has led to many innovative community based experiments in intersectoral action aimed at promoting health²². Unfortunately the enthusiasm of the movement has never been backed by serious research funding to allow the detailed evaluation of policy and practices Healthy Cities has given rise to²³. The spirit of Alma Ata has also been remembered in regions of WHO, most noticeably in the Pan-America Health Organisation. A browse of its website, constructed on the twenty-fifth anniversary of Alma Ata bears witness to this²⁴.

By the end of the twentieth century it was evident that Health for All would not be achieved and that for some Sub-Saharan countries life expectancy was going backwards and other indicators such as immunization rates were in decline²⁵. There was, thus, little to celebrate in 2000. However there was some glimmer of hope on the horizon. Globalisation has seen the struggle for comprehensive primary health care become increasingly global. This is exemplified in the rapid growth of the People's Health Movement²⁶. This Movement draws its inspiration from Alma Ata and many of the key people involved in establishing this network had been inspired by Alma Ata throughout their working lives. The PHM grew from eight non-government groups which came together to organize the First People's Health Assembly held in Savar Bangladesh in December 2000. 1,500 people from 91 countries attended this meeting. It was highly significant that no senior staff from WHO chose to attend but that Halfdan Mahler, the Director General of WHO at the time of Alma Ata, was

there and gave a ringing endorsement of the PHM and the Charter that it launched.

The People's Health Charter is a long document and available on line at <http://www.phmovement.org/resources/phcharter>.

It has been translated into 32 languages. That it is a child of Alma Ata is very clear from this quote:

"Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for All means that powerful interests have to be challenged that globalisation has to be opposed and that political and economic priorities have to be drastically changed" (People's Health Charter Preamble)

It calls for a people centered health sector that is based on comprehensive primary health care. Each ideal embedded in Alma Ata is present in the People's Health Charter. The Charter demands a radical transformation of WHO so that it avoids vertical approaches, ensures independence from corporate interests and involves people's organisation in the World Health Assembly. It also updates the ideas from Alma Ata by examining the impacts of neo-liberalism and economic globalization on health. The Charter addresses more than health services and also makes a series of recommendations about the broader determinants of health (including SAPs, debt and trade). It also notes the crucial importance of the protection of the natural environment, something that Alma Ata did not.

If comprehensive primary health care had been progressively implemented in the 1980s and 1990s and SAPs had not left countries without funds to invest in their health systems, it is quite conceivable that the HIV/AIDS epidemic would not have taken hold in Africa in the way it did²⁷. There were signs, before the untimely death of Dr. LEE Jong Wook in April 2006 that he was prepared to re-claim at least some of the vision of the Alma Ata Declaration. He launched the Commission on the Social Determinants of Health in 2005, he was engaging with the People's Health Movement and the 2005 World Health Report²⁸ noted the lack of co-ordination in health systems and that a multitude of vertical, disease focused programs undermined the capacity of ministries of

health the and development of integrated health systems. His successor, Dr. Margaret Chan, took up her position in January 2007. Her early speeches, reported on the WHO web site, suggest a continued commitment to comprehensive PHC so we must hope that this commitment is followed through by the necessary organizational culture change and resource commitment.

Reviving the spirit: to the way forward in the 21st century

Will the spirit of Alma Ata flourish again in this century? As an active member of the People's Health Movement where the passion for this spirit is evident I believe it will have to, if we are to evolve health systems that are designed to meet people's needs rather than those of the massive medico- industrial complex. Medicine and health care is rapidly becoming one of the biggest global industries. The risks of this were foreshadowed in Alma Ata's plea for "appropriate technology" that is affordable. Today much medical technology is only available to people in rich countries and poor countries have had to fight for access to drugs such as anti-retrovirals at a time when HIV/AIDS is devastating so many countries, especially in Africa.

The industry has little interest in the diseases that affect the poor and increasingly spends effort on "disease mongering"²⁹ on populations in rich countries.

Health care costs are rising in all rich countries partly because of this disease mongering and because of the growth in new medical and pharmaceutical technologies. The issue of increasing health costs is becoming a top policy issue in many countries. Primary health care offers a means of creating a sustainable health system in both rich and poor countries. Most significantly it offers a sustainable and people-centered approach that could be accessible to all. Evidence suggests that primary health care offers a health system that is more equitable, achieves better health outcomes³⁰, affordable³¹ and its effective implementation leads to a more coordinated and effective health system³². There is no doubt that the levels of wealth in the world in the twenty-first century can deliver comprehensive primary health care and so achieve the millennium development goals for all the world' population. Our challenge

to ensure this is not a resources issue but concerns technical know how and political will.

I write this commentary at a time when I am in the middle of my three-year term as a Commissioner on the Commission on the Social Determinants of Health established by WHO in March, 2005. My careful re-reading the Alma Ata Declaration has been a salutary exercise. So much of what we are trying to achieve through the Commission was foreshadowed in it: the need to ensure all aspects of life are health promoting; the focus on the crucial importance of working with other sectors; the central importance of achieving health equity; the need for accessible and appropriate health services; the need for community and civil society involvement; the fact that health is important to both social and economic development and its attainment is a social and human right; the focus on the importance of solidarity to achieving wide-spread good health. Thus the Declaration serves as a vital reminder that good intentions and fine words are not enough to bring about social change. It is also, however a powerful reminder of the value of a vision and an ideal around which people can rally. Thus the challenge for the CSDH is to take up the Alma Ata baton and produce an equally inspiring vision that can marshal political and social support from civil society and governments who are committed to equitable promotion of health. Primary health care is not a technical package of measures that can be imposed from outside. It comes from and grows out of people's lived experience in their communities and is strengthened by collective action and by a state which sees as its central goal, not economic development, but ensuring that health and well-being are maximised for all its citizens. When comprehensive primary health is implemented fully the security, safety and hope it brings will see a growth in solidarity and willingness of people to continue the struggle for health for all.

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