Primary Health Care

Alma-Ata and after
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The Alma-Ata Conference on Primary Health Care in 1978 marked a turning point in WHO's history and in international cooperation in health. Attempts to put the decisions of that conference into practice have not always been successful, but the principles that were formulated then remain as valid as ever. The author, who was one of the main moving spirits behind this unique event, puts things into perspective.

During the 20 years since the Alma-Ata Conference in 1978, fundamental changes have taken place throughout the world, but the outcome of the conference remains as important as ever. I believe the reason for this is that the International Conference on Primary Health Care, under the auspices of WHO and UNICEF, was shaped by the entire process of international cooperation in health, which is a matter that concerns everyone.

Early glimmerings of the health-for-all vision

The nineteenth century saw the blossoming of microbiology and other sciences, success in combating infectious diseases, international quarantine conventions, and insight into the social causes of tuberculosis and many other diseases. It also saw the beginning of social security systems in Germany and other European countries, the rapid growth of medical literature and health statistics, and increasingly frequent international congresses of doctors and scientists. After the First World War and the events of 1917 the right of the people to health care was upheld with the creation of a state health system in Soviet Russia under conditions of incredible hardship.

The merits of the Soviet public health system were widely acknowledged (as well as questioned), but it was not until after the shock of the Second World War that attempts were made to build a comprehensive national health service in other countries such as the United Kingdom. At the same time, in 1946 when the United Nations system took shape, the eminent "founding fathers" of WHO wrote in its Constitution that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every

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human being without distinction of race, religion, political belief, economic or social condition” and that “governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures”.

How to put this into practice amidst the devastation and uncertainties of the immediate post-war period was by no means self-evident. The structure and functions of the new Organization were further complicated by the unexpected and unexplained withdrawal of the USSR and other socialist countries for almost 10 years. They were regarded as “inactive Members” of WHO, since the possibility of leaving the Organization had not been foreseen in the Constitution. This complication partly accounts for the fact that WHO was from the outset not entirely balanced, and it may have helped to make relatively “simple and inexpensive” projects of eliminating diseases such as malaria and yaws seem attractive. The wonders of DDT and antibiotics provided encouragement, but the task turned out to be much more complex than expected, and by the mid-1960s these efforts had reached an impasse.

Meanwhile, decolonization and political conflict had divided the world into strongly opposed military and political groupings with a rapidly developing “third world”. The need for cooperation and information sharing was acutely felt, and in the field of health WHO and UNICEF played a leading role in meeting it. The needs of developing countries were increasingly recognized and discussed in international forums, but the question of how to break out of the vicious circle of poverty, hunger and sickness usually remained unanswered. The proclaimed right to health thus remained as distant a goal as ever, in developing countries because of poverty, in the developed ones because of inequity and the rising cost of medicine.

In the USSR and other socialist countries, enthusiasm about the foundations and principles of state health care remained, but increasing difficulties were arising. These included inadequate budgetary allocations, slowness in the provision of medicines and modern technical equipment, and the low pay of doctors and other health workers. Although quite good services were provided at the main medical centres, there was a widening gap between the demand for health care and its supply, particularly on the periphery. Additional hospital beds and accelerated training for doctors and nurses helped to mitigate the problem but did not solve it.

Clearly, the question of how to ensure “the health of all peoples” had yet to be answered, and it was debated during the 1970s, particularly with regard to WHO’s role in scientific development and technical assistance to developing countries. Highly qualified specialists in “systemology”, medical geography, mathematics and so forth were engaged by WHO to work out systems and strategies for health development, but no alternatives to the existing systems emerged. What was required to ensure that health services and systems became effective? How was public and government attention to be drawn to the needs of health so that these systems
could receive the support they needed? What kinds of advice should be given to developing countries?

Dr Halfdan Mahler, who became Director-General of WHO in 1973, played a very active part in stimulating debate on these questions. It was during this period that the idea of “health for all by the year 2000” began to emerge as a suitably visionary goal, and that of primary health care as a realistic strategy for attaining it. Initially, many regarded primary health care as a rudimentary form of medical care, on a par with traditional healers, “barefoot doctors”, and the like. They saw it as suitable mainly for places in which no modern medicine was available. The issue was debated not only by health specialists but by sociologists, economists and politicians, and eventually the definition of primary health care emerged as “the place of first contact with a national health care system”. Such contact may take place in a polyclinic, the consulting room of a private doctor, a rural primary health care centre, and many other settings, depending on the health system concerned. Mutual understanding was significantly helped by the crisis in private medicine and the quest for “national health care goals” in the richest country in the world, the United States, as well as growing disillusionment with the “barefoot doctor” approach in China. The idea offered a way forward at a time when most other ideas seemed to have failed.

**The Alma-Ata Conference**

The need for more thorough discussion was felt, and the Soviet Union proposed that a special international conference on health care systems should be convened. The proposal gradually won support, and WHO received invitations from Colombia, Egypt and other countries to hold the conference there, but for various reasons those invitations lapsed and ultimately nothing remained but to host the conference in the Soviet Union. Some members of the Executive Board felt it would be preferable not to hold it in Moscow, Leningrad, Kiev or another major city in the European part of the USSR but in Central Asia. Tashkent was originally favoured, but the choice eventually fell on Alma-Ata, partly because the authorities showed great eagerness to host the conference and were willing to make a considerable financial commitment to it.

The conference was held from 6 to 12 September 1978, under the chairmanship of B.V. Petrovsky, Minister of Health of the Soviet Union. Delegates from 134 countries attended. They included Princess Ashraf Pahlavi from Iran, Senator Edward Kennedy from the United States, R. Altman, the Vice-President of Costa Rica, and many ministers of health and other officials. Representatives of 67 international organizations also attended. The conference discussed detailed reports from WHO and its six regions, from UNICEF, and from the Soviet Union, as well as a wide range of information from the other countries and organizations participating. The discussions were very lively, and showed a high level of commitment to finding valid and acceptable approaches to health care.
The delegates were invited to spend two days in the middle of the conference learning about the primary care establishments in Kazakhstan, Uzbekistan and Kirgizia. At the same time they could visit a wide variety of urban and village hospitals, polyclinics, midwifery units and other health institutions in the vast oblast of Alma-Ata itself, as well as those of Karaganda, Temirtau, Chimkent, Samarkand, Bukhara, Tashkent, Frunze (now Bishkek) and others. This proved to be a recklessly ambitious programme. The guests were invited beforehand (democracy at work!) to put their names down for one or other of the 63 itineraries on offer. Especially with the lack of experience of the local organizers, this naturally caused difficulties as the number of expected guests who could be accommodated by any one institution was limited – many of them were small. The foreign guests naturally had a preference for fabled cities such as Bukhara, Samarkand and Tashkent. None the less, everything seemed to get more or less sorted out, though with difficulty.

An unanticipated “disaster” struck on the last evening before the excursions. The organizers discovered to their consternation that the capacity of the aircraft intended for flights to other cities and republics differed significantly from what had been planned, partly because of the size of the landing strips at local airdromes. This necessitated radical alterations in the membership of the intended groups. An emergency meeting of the organizing committee was convened, and they spent the night telephoning the foreign delegates and, having woken them up with difficulty, persuading them to fly for example not to Chimkent but to Temirtau, or to Karaganda instead of Frunze. Early the next morning they were woken up again to make sure they got onto the right bus or aircraft at the right time. That was finally achieved, though with great difficulty.

To give them their due, most of the delegates even when half asleep showed admirable understanding of the situation and sympathized with the organizers. For the remaining few who were less compliant, there were still a few seats available for conveying them to the most attractive places. Until all the groups had driven or flown off on their various itineraries, the tension at headquarters had been similar to that of a crisis committee in charge of a volcanic eruption or an earthquake. However, all the trips were successful and interesting, and the guests showed a meticulous and well-informed interest in the medical establishments they saw. The fact that the paint was still wet on the walls of some of the buildings they saw did not seem to bother them unduly.

This extensive exhibition of local efforts to meet health needs, together with the reports on many countries available at the Conference, certainly contributed to its success, but the most important factor was the complete frankness of the discussions. Both in the plenary meetings and in the subgroups intense effort was put into making “Health for All” a meaningful slogan with a realistic agenda behind it. Twenty-two years remained until the end of the century, and it seemed that in that
time, and with such a deployment of forces throughout the world, and with the rapid changes that were occurring, an unprecedented amount might really be achieved for health.

The conference culminated in the adoption of the Alma-Ata Declaration and 22 recommendations. The Declaration stated that a main task of governments, international organizations and of the whole world community should be “the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”. The key to attaining that objective was the development of national health care systems, at the core of which was primary health care – “the central function and main focus of the country’s health system”. In the recommendations these statements were spelt out in more detail.

That was a very daring undertaking. It was the first time that such a statement had been made. It largely foreshadowed the later development of health care in many countries and the activity of many international organizations. It was also perhaps the natural culmination of medical and humanitarian thinking that had been evolving since the beginning of this century. It reflected a deep desire to counteract the fatalistic feeling that long-term political and socioeconomic trends were bringing the world closer and closer to the danger of self-destruction, whether from universal nuclear warfare, the escalation of “conventional wars”, or from the slow but inexorable destruction of the world’s ecological balance.

**After Alma-Ata**

Of course, there were dissenting voices as well, stressing the absurdity of aiming for such a patently unachievable goal as “health for all”, especially in the light of WHO’s own maximalist definition of health as “a state of complete well-being”. But even *The Lancet* of the United Kingdom announced “High hopes at Alma-Ata”, and conceded, perhaps grudgingly, that the document was “important enough, short enough, and sufficiently comprehensible (by international standards) to merit examination by all members of the health professions, especially by doctors”, and that it contained “much that is relevant to the developed countries, who often seem slow to respond to avoidable hazards”.

It proved impossible to belittle the achievements of the Alma-Ata Conference.

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They were confirmed by the World Health Assembly and then by the General Assembly of the United Nations in 1979, and in other international forums. In subsequent years the Alma-Ata Conference and its decisions have been referred to not just as “the most promising and shining event of 1978” but as a major turning point in the development of health care throughout the world. In many countries an enormous amount has been done to put those decisions into effect through a deeper understanding of the goals of primary health care and the methods of attaining them.
I think the most correct and far-sighted conclusions concerning the Alma-Ata Conference were drawn by the countries of the European region, or, more precisely, western Europe. They were more serious about working out both the strategy of “health for all by the year 2000” and the criteria for progress in implementing the primary health care approach. Those countries were clearly ahead not only of the developing countries but also of the United States and of the Soviet Union. WHO’s European Office played an important part in promoting the necessary organization and methodology within countries.

There are clearly a number of objective reasons for Europe taking the lead in this way. In the first place, it is important to remember that in the early stages of the development of WHO Europe was a region of large but melting colonial icebergs. After decolonization receptivity to Europe’s influence persisted in the developing countries, but it was accompanied by demands for “compensation for plundered resources” and for increasing economic and technological assistance. The western European countries were unable to meet those demands, but they could not simply brush them aside either, particularly as within Europe positions on such matters were beginning to diverge. At the same time, an increasing flow of immigration to western Europe was adding to the burden on its social structures and changing the composition of its populations and ways of life.

In the second place, health care in western Europe tended to be a more varied, dynamic and flexible affair than in other parts of the world. With its many different systems of medical practice, health insurance, public health and environmental health regulations, there was already a highly active search going on for more effective systems and approaches. There was also a high level of social activism and public concern about the health and social services. All of this provided a favourable setting for the health-for-all “movement” as it began to be called.

In North America, spending on health and medicine was more extravagant and less efficient than anywhere else in the world, but society still somehow tolerated this, in spite of talk about a crisis. Rather than universal access to affordable care, people were interested in other aspects of medicine, particularly the development of medical and biological research and the achievements of the medical and pharmaceutical industries. It is true that after the Alma-Ata Conference the United States supported its endorsement by the United Nations and, in the United States itself, the Institute of Medicine of the Academy of Sciences made one of the first appeals that had ever been heard by the public in that country for the development of primary health care; but nothing much came of these encouraging signs. The time had not yet come for major changes.

Perhaps the most unexpected outcome of all was that the significance of the Alma-Ata Declaration and the related decisions – perceived everywhere else in the world as the triumph of socialist health care – were not understood by the top leadership of
the Soviet Union. Once it was over, they simply ignored the findings of the Alma-Ata Conference. That may have been because the favourable assessment of Soviet health care by the participants in the Conference was interpreted as proof that for us the problem had been solved. Conversely, it may have been because the Conference showed the necessity for major change if the social and health needs of the population were to be met, but because of the arms race and increasing difficulties in the economy, it was felt that nothing could be done about it. At all events, the ship of state did not change course, and what that subsequently led to is well known.

The President of the Alma-Ata Conference, Academician Petrovski, who initiated a whole series of health care reforms, came to be regarded as an inconvenience. He soon retired from his ministerial post, and his successors, who came and went quickly, were equally unable to convince the leaders of the Party and the State to give health care the attention it needs in today’s world. Nor did subsequent appeals to the leaders after Brezhnev, and then to Gorbachev with his “perestroika” and “new thinking”, meet with any better success. They did not listen – or they could not hear. Worse was to follow, with the collapse of the USSR and its economic system, which also began the destruction of the unified health system.

And now?

The new civil servants in the Russian Federation were puzzled by the conference to mark the fifteenth anniversary of the Alma-Ata Declaration in the capital of Kazakhstan in December 1993. It was attended by the Director-General of UNICEF, three of WHO’s Regional Directors, delegates and experts from Botswana, China, Germany, Indonesia, Islamic Republic of Iran, Norway, Turkey, the United States, the former Soviet republics and other countries. Surely, they thought, that Declaration was out of date after the collapse of the USSR and the transition from socialist health care to private medical practice, particularly as the year 2000 was not far off, and the world situation was not improving. Indeed, in many ways it was deteriorating, what with local wars, forced migration and a long list of other major problems.

It may be true that the view from the Russian Federation is sombre at the moment, and that the break-up of the health care system seems representative of the many troubles our society is now facing, but this does not make the decisions of the Alma-Ata Conference irrelevant. They continue to be a major reference point for the health sector reform efforts that are taking place around the world. Indeed it could be argued that they are more important than ever now that the impracticability of other approaches is being so clearly demonstrated.

Many lessons can be drawn from the Alma-Ata Conference and the 20 years that have followed, but I will content myself with naming only three of them.

First, it marked the beginning of a new international understanding of the real dimensions of health care needs, especially in developing countries, and of the enormous social and economic problems involved. It made it clear that meeting these needs was one of the foremost responsibilities of any government.
Second, it brought to a close the era in which “technical assistance” and efforts at disease eradication could be thought of as a sufficient activity for WHO. By showing that it was both necessary and possible to redesign health systems on the basis of primary health care, it pointed the way towards national self-reliance in health.

Third, it opened up new prospects for international cooperation in health. Long before the current talk of globalization, it demonstrated not only the advantages but the necessity of sharing information and strategies for promoting health and preventing and controlling diseases.

The conviction that health is a human right and that governments must uphold that right for present and future generations is the most important message that comes to us from Alma-Ata as we approach the year 2000.

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**Extracts from the Declaration of Alma-Ata, 1978**

Article VII. Primary health care: ...
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate; ...

Article X. An acceptable level of health for all the people of the world ... can be attained through a fuller and better use of the world’s resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.