Ten years after Alma-Ata

by John H. Bryant

Ten years after Alma-Ata

The International Conference on Primary Health Care (PHC), sponsored by WHO and UNICEF, took place in Alma-Ata, USSR, in 1978, just 10 years ago. Decisions by the Member States at the World Health Assembly in 1977, and the subsequent Declaration of Alma-Ata launched the movement toward Health for All (HFA) by the Year 2000. The results have since found their place in the history of global public health movements.

What has happened since Alma-Ata? What has been the progress? The success stories? The failures? Where does HFA stand? Is the concept still alive and being worked into the fabric of health services policies and programmes? Is it still evolving in the face of new problems and insights? Or has there been a fading of vision, a crumbling of resolve? What new resources are required? What new mechanisms? And new partnerships? What new strategies are called for?

The larger question—"What have been the problems and progress in pursuing HFA since Alma-Ata?" is immensely complex. The question has social, economic, ecological, political, biomedical and organizational aspects that apply to six continents, more than 160 countries, and countless cultures and communities.

My approach is personal and reflective—what this decade has looked like to one who has been involved in the HFA movement, centrally at times, peripherally at others, but always with interest. What follows, then, is an effort to look broadly over the complex terrain that we call Health for All, trying to pick out salient features of the topography: problems that are most serious and widespread, obstacles that are most intractable, and possibilities that are most hopeful.

The first guiding principle of HFA is that primary health care (PHC) is seen as the key to achieving HFA. The original description of PHC in the Declaration of Alma-Ata is splendid and succinct (see page 18). But let me point out what PHC is not:

- it is not primary medical care;
- it is not only first contact medical or health care;
- it is not only health services for all;

and what it is and does:

- it is intended to reach everybody, particularly those in greatest need;
- it is intended to reach to the home and family level, and not be limited to health facilities;
- it is intended to involve a continuing relationship with persons and families.

PHC is the key to HFA, and should include the following five concepts:

**Universal coverage of the population, with care provided according to need**

This is the call of equity. No one should be left out, no matter how poor or how remote. If all cannot be served, those most in need should have priority. Here is the All in Health for All.

This article sums up a 60-page document prepared by Professor Bryant for the Riga Conference earlier this year, when the concepts of Alma-Ata were resoundingly reaffirmed.

Photo WHO

10

WORLD HEALTH, Aug./Sept. 1988
Services should be promotive, preventive, curative and rehabilitative

Services should not only be curative, but should also promote the population’s understanding of health and healthy styles of life, and reach toward the root causes of disease with preventive emphasis. Treatment of illness and rehabilitation are important as well.

Services should be effective, culturally acceptable, affordable and manageable

Services that are not effective make a mockery out of universal coverage and HFA. But effectiveness cannot be at the cost of cultural acceptability—indeed the two are mutually dependent. Services must be affordable in local terms, because of limited governmental resources and because the community will often have to share in the costs.

Communities should be involved so as to promote self-reliance

The community’s role must be more than that of responding to services planned and designed from the outside. The community should be actively involved in the entire process of defining health problems and needs, developing solutions, and implementing and evaluating programmes.

Approaches to health should relate to other sectors of development

The causes of ill-health are not limited to factors that relate directly to health, and the paths to be taken to deal with ill-health must not be solely health interventions. Education for literacy, income supplementation, clean water and sanitation, improved housing, ecological sustainability, more effective marketing of products, building of roads or waterways, enhancing roles for women—all these may have a substantial impact on health.

Health for all—a wistful dream or living reality?

What has been the experience with HFA? Answers are mixed, depending on where one looks, whom one asks, and what one expects. To be sure, there have been naive hopes and false promises, but there have also been clear vision and carefully built progress. Our world is not so simple that work with highly complex problems can be summarised with “yes” or “no”, and we should not reach for such easy generalisations.
Let us be clear: Health for all has been more than a wistful dream, captured in a slogan, supported annually from the podium of World Health Assemblies. There has been political commitment that has forced policies, budget and programmes in support of PHC where it was needed. There have been stands taken in favour of equity and against another 500 beds for an urban centre. Medical students have been learning that excellence can be defined in terms of serving communities as well as in the use of sophisticated technology. These events have been spurred on by HFA. How often? In how many places? How does one quantify the diffusion of commitment and consequent action? One hears it and reads of it in a hundred sources. One sees it in the field and knows it is real. One does it and measures it, and shows others, and they show others.

We should not forget where HFA came from. It did not spring without antecedents from WHO or UNICEF or the men and women who put the concept together a decade ago in Alma-Ata and Geneva. The underlying concepts had been taking root around the world over a number of years. It was the fact that PHC had a solid beginning in some developed countries that made it reasonable to think about commitments to improving health on a worldwide basis.

Further, what was now being seen as technically possible was also seen as politically and socially imperative—that the half of the world that was deprived and suffering should have hope of achieving some small part of what the other half of the world enjoyed through the benefits of affluence and modernization.

The genius of WHO and UNICEF and the Member States who led the way toward this goal of HFA was to recognise that the right moment was at hand to launch such an ambitious programme, and to identify the critical ingredients that must be involved—political commitment, ethical precepts, and technical expertise.
One of WHO's global indicators for monitoring progress toward HFA is the availability of PHC. Most developed countries have already achieved full coverage, but even there some groups, such as poor or remote populations, have limited access. In the developing countries coverage is very inequitable, with the rural and urban poor being particularly disadvantaged. Immunization rates, which can be seen as an indicator of coverage, increased in the years 1970 to 1980 from 5 per cent to 40 per cent; in some countries the rates have reached ideal levels, but in a number of the least developed countries the coverage is less than 15 per cent.

In 1960, there were 72 countries where the mortality rate among children under five years of age was 178 or more per 1,000 live births; in 1985, that number was halved, to only 34 countries.

It is clear, therefore, that many countries have been making considerable and even remarkable progress in improving their health and development conditions. But others have either not improved at all, or the rates of change have been slow. In India and Pakistan, for example, there are more deaths of children under five than in all 46 African countries.

It is also important to look at indicators that go beyond health as such but relate closely to health: the absolute number of illiterate women in developing countries is increasing, and the literacy gap between men and women is widening; poverty is increasing—1,000 million people in the Third World are living in absolute poverty.

It is apparent, then, that advances being made with respect to HFA vary immensely from country to country and region to region—and that if we compare the most advanced with the least advanced countries we are comparing progress with tragedy.

A number of participants at the Alma-Ata Conference were concerned that the principles of HFA would be seen as applying mainly, even exclusively, to the developing countries. But now that the
Ten years after Alma-Ata

As here in Pakistan, health personnel need to discuss both personal health problems but also all the other factors involved – such as literacy, clean water and sanitation, and improved roles for women.

Photo WHO/Zafar

developed countries, particularly Europe, have taken serious steps toward an HFA strategy, it is curious to look back and realise that there was once a serious question as to whether the matter even applied to those countries. This curiosity tells us how far the HFA effort has come conceptually, methodologically and politically since the time of Alma-Ata, and how far we have come in our acceptance of it.

On the positive side, in the US, as in Japan and Australia, there have been striking decreases in cardiovascular and cerebrovascular mortality rates, which is in contrast to Eastern Europe, where these rates continue to rise.

But successes in advancing health are not limited to the developed world. There is a broad band of developing countries that have made distinct progress in dealing with the problem of underdevelopment. To cite only one example among many, Thailand is a country clearly on the move with respect to health and other aspects of development. In terms of mortality among under-fives, it progressed from 195 in 1950-55, to 61 in 1980-85, and is projected to reach 32 by 1995-2000. The country has embarked on a remarkable village-based approach to identifying and pursuing the basic minimum needs of life.

The urban poor

Health problems of the urban poor seem to represent many of the worst problems of Third World under-development – patterns of disease that are a mosaic of both developed and developing societies; health services that are an ineffective mixture of high technology care for those who can afford to pay, with few or no services designed to reach out to the burgeoning squatter settlements, all contained uneasily in cities whose growth is economically and ecologically unsound.

The costs of maintaining the cities, particularly the large urban conglomerates, is very great; bringing food and water in and getting rid of garbage and human waste is much more costly for large than small cities, and the ecologic devastation of the surrounding areas is unparalleled. Indeed, the costs of maintaining the cities is a major contributor to Third World indebtedness.

Another pervasive deficiency in the Third World relates to health personnel who are not adequately prepared to function effectively in community-based or district level health services. This is true of workers at all levels, but the most damaging deficiency is at the level of the doctors. Typically, the medical education of the doctor, and often of nurses as well, is curative-oriented and hospital-based, provided in an institution where public health or community medicine are given little attention and less respect. Such health professionals are unlikely to be useful in leadership roles that require them to relate to communities, assess needs, and plan, manage and evaluate programmes, and oversee the in-service training of other personnel. Worse, lacking such competencies but occupying the leadership role, the doctor effectively obstructs the effective function of the rest of the health team.

It is probably fair to say that nursing and nursing education are not as remote from these issues as are their medical counterparts. While there are many exceptions,
nursing leadership has been generally responsive to the problems and possibilities represented by HFA, and this is reflected in their literature and programmes. In the field, where there is a public health and PHC orientation, nursing is often the mainstay of the service.

Ten years since Alma-Ata

It is now clear that the concepts and principles of HFA elaborated at Alma-Ata in 1978 provided the world with ethical precepts, political imperatives and technical directions that have since become critical guidelines for the health and development community worldwide.

What has been surprising is how widely HFA has been accepted and used, in whole or in part, by health policy-makers, programme planners, funding organizations, politicians, health personnel, school teachers, newspaper reporters, professors, mothers, schoolchildren. A further surprise is how influential it has been in the policies and programmes of the developed countries, given the initial concern that the more affluent part of the world would consider HFA as applying to poor countries only.

Less surprising, but no less gratifying has been the general acceptance of the HFA strategy by the poorer countries as they have used it in formulating their national and regional strategies. Here is the acid test of HFA.

The quest for HFA will not end, not at the year 2000, nor at the year 2100. No country solves all of its health problems, and new problems continue to emerge in every country. So while the goal of HFA remains unchanging, the targets will shift, from those suited for the decade preceding the year 2000 to those relative to future times and places. Here, at the midpoint between Alma-Ata and the year 2000, our goals should be:

- to identify the critical challenges to be met between now and the turn of the century;
- to show that headway can be made against the most solution-resistant problems;
- to lay the groundwork for appropriate changes of strategy necessary to consolidate the pursuit of HFA beyond the year 2000.