The declaration of Alma Ata: still relevant after all these years?

Next year sees the 30th anniversary of the declaration of Alma Ata. Primary health care 'based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people's full participation and at a cost that the community and country can afford' was to be the key to delivering health for all by the year 2000 (1) . This ambitious vision resonated powerfully with a generation of leftward leaning doctors, plying their trade in what is often regarded as a golden age for general practice in this country. How relevant is the declaration today?

Early efforts at primary care expansion in the late 1970s and early 1980s were overtaken in many parts of the developing world by economic crisis, sharp reductions in public spending, political instability, and emerging disease. The social and political goals of Alma Ata provoked early ideological opposition and were never fully embraced in market-oriented, capitalist countries. In many health systems, a medical model of primary care dominated by professional vested interests resisted the expansion of community level health workers with poorer training. Such programmes anyway proved difficult to sustain and there was little empirical research with which to justify them. 'Selective' primary health care and packages of low cost interventions such as GOBI-FFF (growth monitoring, oral rehydration, breast feeding, immunization; female education, family spacing, food supplements) in some respects distorted the spirit of Alma Ata (2). The failure in most countries to provide even limited packages, coupled with the proliferation of 'vertical' initiatives to address specific global health problems, hastened its eclipse. Geographic and financial inaccessibility, limited resources, erratic drug supply, and faulty equipment have left many countries' primary care services disappointingly limited in their range, coverage, and impact. Primary health care was hardly mentioned in the Millenium Declaration (3).

However, after years of relative strategic neglect, WHO is once more giving prominence to the development of primary health care for several inter-related

reasons (4). Low and middle income countries, like high income ones, face a future of increasing prevalence of non-communicable illness. This shift has already led to the coexistence of persisting infectious disease, nutrition and reproductive health problems alongside emerging non-communicable disease and related risk factors (such as hypertension, obesity, diabetes, stroke, and cardiovascular disease). The challenge this epidemiological transition poses to existing health systems is considerable. For the most part, they are oriented to maternal and child health and the care of acute, episodic illness. Primary care services appropriate to future needs will require the capacity to deliver effective chronic disease management.

At the half way stage, progress towards the Millenium Development Goals (MDGs) is least impressive where the neediest populations live, notably in Sub-Saharan Africa (5). Ironically, the limitations to top-down, 'single issue' programmes (usually steered from Washington or Geneva) were highlighted at Alma Ata. Global Funds tackling priority diseases like AIDS, tuberculosis and malaria, may undermine broader health service delivery through duplication of effort, distortion of national health plans and budgets, and particularly through diversion of scarce trained staff. Primary health care, integrating progammes horizontally, is clearly essential to delivery of the MDGs.

Primary care is also the key interface linking, on the one hand, ambulatory care with hospital and specialty services and, on the other, individual clinical care with community-wide health, nutrition, and family planning programmes. Failure to recognise the interrelationship between component levels of a district health system has resulted in great inefficiency (6). In low income countries this first level of care could deal with up to 90% of demands (7). Evidence suggests that health systems which are primary care oriented are more likely to deliver better health outcomes, greater public satisfaction – at lower costs (8).

No single system of primary health care can be universally applicable. A major challenge is to establish the most effective combinations of interventions that can target multiple conditions and risk factors affecting key groups (children, women, and older adults, for example) and which are appropriately adapted to local epidemiological, economic, and socio-cultural contexts. 'Clustering' interventions can

achieve comprehensiveness in the face of resource constraints. Intervention clusters are likely to include the integrated management of childhood illnesses (IMCI); maternal and reproductive health services; clinic and community-based management of tuberculosis, HIV/AIDS, and sexually transmitted infections; malaria management; management of hypertension, other cardiovascular risk factors, stroke and cardiovascular disease; mental illness and substance abuse (9). Not only does the primary care level constitute the first point of patient or family contact, it is also a critical base for extending care to communities and vulnerable groups. Outreach services may focus on individual preventive measures (such as immunization, vitamin A, or oral rehydration therapy) or community-wide health-promoting efforts (such as education on child nutrition or adult diet and exercise). These services depend substantially on community support and mechanisms for identifying, training, and supporting village or community health workers (10, 11).

The empirical evidence with regard to large-scale and routine primary care programmes is scant (6). There is plenty of evidence for cost-effective interventions that could vastly improve maternal and child health (12), for example, but less evidence on how to ensure these services reach the most vulnerable populations to lasting effect (13). A community-focused operational research agenda has to date been neglected in favour of the evidence base for individual interventions. Evaluations of new forms of organising primary care services in specific settings are required. Such research is complex because it is context-specific and dependent on local capacity and commitment.

There remains the over-riding and universal challenge of affordability. The place of user charges for primary care remains contested for they have repeatedly been shown to deter those most likely to benefit from preventive activities (14). Indeed, one way to address this is to provide financial incentives for poorer people to visit services. Methods of demand-side financing where money or vouchers are given to the poorest people to increase access to particular services such as maternity care, are being piloted in many countries (15,16). Other ways to improve equitable access include the monitoring of service delivery and health outcomes by separate population groups, and the provision of incentives to service providers to deliver services to these groups.

In low and middle income countries, most primary care will continue to be provided by private and non-governmental organisations.

In many places, partly as a result of international and internal migration, there are crippling shortfalls in human resources, hence the renewed interest in the possible contribution of community level personnel. Ironically, poor countries which emulated training standards in industrialised countries have been most vulnerable to poaching by them (17). One of the greatest challenges is to overcome the loss of motivation and sense of resignation of many primary care workers who work in under-staffed settings. They lack consistent managerial support and have grown accustomed to a norm of inadequate service delivery (18). In most developing countries primary care roles are regarded as low status, less valued than hospital medicine by both the public and policymakers. Only high level political commitment, adequate governance and funding will raise the status of primary care and attract suitable workers to it.

Many industrialised countries have extensively improved their primary tiers, influenced to varying degrees by Alma Ata. For others, including the United Kingdom, the rhetoric of Alma Ata was of mostly symbolic importance. Pivotal turning points in the post war development of general practice – notably the Family Doctors Charter of 1966 – were already yielding benefits. The UK already boasted some of the best primary medical care in the developed world. To British general practice in large measure has been attributed the relative efficiency of the National Health Service. Ironically, moves under the current Labour government to create a market for these services threatens to fragment primary health care (19). Experience from North America suggests that parcelling up the care of chronic diseases between different commercial companies principally concerned to increase profit margins results in less efficient (higher transaction costs) and more inequitable (excluding patients at higher risk) care (20). For effective primary health care is more than a simple summation of individual technological interventions. Its power resides in linking different disciplines, integrating different elements of disease management, stressing early prevention and the maintenance of health.

In summary, the declaration of Alma Ata resonates today in the face of much unfinished business. Responding to the rapid health transitions under way in all

socioeconomic contexts, primary care continues to offer the potential for major health and, hence, development gains that both provide good value for money and, crucially, enhance equity. In this country the untrammelled advance of health care markets threatens to do the opposite. They are likely to erode the social compact and levels of public support that hold the NHS together. The declaration of Alma Ata helped to entrench the idea of health care as a human right. This anniversary provides a salutary reminder of what we are placing at risk.

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