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40 Jahre Alma-Ata: Was können wir noch erwarten?

Origins, history and forecast

Social determinants of health receive too little attention

Von David Sanders

In 1978 at the historic International Conference on Primary Health Care (PHC), WHO and UNICEF advocated PHC to achieve Health for All by the Year 2000. PHC was a strategy to provide more equitable, appropriate and effective basic health care and also address the underlying social, economic and political causes of poor health ('social determinants'). Its principles included: universal access and equitable coverage; comprehensive care emphasizing disease prevention and health promotion; community and individual participation in health policy, planning and provision; inter-sectoral action; appropriate technology and cost-effective use of available resources (Bryant & Richmond, 2008). These principles were to apply to all levels of the health system and also shape the eight elements or programmes of PHC. Notably, the 'elements' of PHC did not include non-communicable diseases or mental ill-health which were dominant in industrialised countries, while in low and middle-income countries (LMICs) they were only just emerging. Their exclusion reinforced a perception that PHC, while promoted as a global policy for health development, was, in reality, aimed mainly at poor countries.

Health extension agents (community health workers) in Ethiopia. Photo: © David Sanders

Progress in Primary Health Care (PHC) implementation

Substantial support for PHC and significant achievements in some of its programmes occurred in the first two decades after Alma Ata. Remarkable progress, especially in maternal and child health, was achieved in countries such as China, Zimbabwe, Nicaragua and Brazil. Such progress usually followed national political struggles involving mobilized and self-organised populations who demanded government investment in health and provided the human infrastructure for decentralized and comprehensive health care, accelerating implementation of PHC.

However, the 1970s debt crisis, structural adjustment, and neoliberal global economic policies resulted in declining political support for community-based development efforts, as well as state withdrawal from public service provision, including health care (World Health Organisation (WHO) (1998). Health for All Renewal). This undermined the full and widespread implementation of PHC. By the early 1990s, the commitment to PHC as originally conceived, declined, as 'health sector reform' - neoliberal policies applied to the health sector – was advanced by the World Bank and supported by the US government. Its main features

included a strong focus on economic and technical efficiency, manifesting as 'essential packages of health care', private sector 'partnerships', and a shift away from policies and programmes to address social determinants of health (World Bank. (1993). World Development Report: Investing in Health.)

Health extension agent (community health worker) in Ethiopia. Photo: © David Sanders

Is Primary Health Care still relevant?

In 2018, despite global progress in health – with increases in life expectancy and reductions in young child and maternal mortality - inequalities in health outcomes between rich and poor, both within and between countries, have increased. This, together with the growing impact of non-communicable diseases, especially in LMICs, and the emergence of new threats such as swine flu, Ebola and other viral diseases, have re-emphasized the need for responsive and

robust health systems and tackling the social determinants of health, which are now increasingly driven by neoliberal economic globalisation. PHC, as originally espoused, offers a comprehensive strategy, driven by the health sector, to address these challenges.

A recent evaluation of ten low- and middle-income countries (LMICs) that achieved MDGs 4 and 5 faster than other comparable countries : Bangladesh, Cambodia, China, Egypt, Ethiopia, Lao PDR, Nepal, Peru, Rwanda, and Viet Nam, found that 'these countries engage multiple sectors to address crucial health determinants. Around half the reduction in child mortality in LMICs since 1990 is the result of health sector investments, the other half (...) to investments made in sectors outside health'. The health sector actions included skilled care at birth, immunization and family planning, utilising community-based health workers in large numbers and monitoring progress. The intersectoral actions included water and sanitation, education, and involving women in policy formulation and programme implementation. Although the contexts were different, in all countries there was strong governmental 'political will' to health and social equity (Success factors for reducing maternal and child mortality. Bulletin of the World Health Organization, 2014, 92(7), 533–544). These experiences support the original vision of comprehensive PHC (CPHC) that combines basic health care, especially focussed at primary and community levels, with intersectoral action and community participation.

Can PHC be revitalised?

Whether Primary Health Care can be revitalised is posed on the anniversaries of the Alma Ata Declaration. This year is the 40th anniversary and again it will be celebrated. Are such celebrations merely nostalgic or is PHC still relevant today? In 2008, on the 30th anniversary, meetings were held in all WHO regions and a special series in the Lancet expressed the continuing interest in comprehensive primary health care (CPHC). This interest was partially a recognition that mainstream health reforms were accompanied by increasing inequities in health outcomes, and the weakening and fragmentation of health systems and their commercialisation. These informed the re-assertion of PHC as the core strategy to address these linked challenges (World Health Organization. (2013). The World Health Report 2008 - Primary Health Care - Now More Than Ever).

It is important to note the geo-political context in which PHC emerged in 1978. Early in the Declaration it is stated: 'Economic and social development, based on a New International Economic Order (NIEO), is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries' (World Health Organisation (WHO) and UNICEF. Report of the International Conference on Primary Health Care 1978). The NIEO implied a global realignment of structural international power relationships (seen as biased towards the industrial countries), thus threatening the prevailing status quo (Cox, R. W. (1979). Ideologies and the New International Economic Order: reflections on some recent literature).

Ms. Kariya Mohamed Abbakar, a 50 year old woman from Jebel Saiey, North Darfur, arrives at her shelter in the Abu Shouk camp for internally displaced persons (IDP), with jerrycans full of water from the nearest water point. Kariya has been living in the IDP camp for the past 10 years and she needs to go for water once a week. The water point is a long walk from her shelter in the camp. Because of the labour involved and the cost of the water, she and her family must limit their consumption of water to 80 litres per week, while a typical person in a developed nation elsewhere in the world would use, on average, 400 litres of water per day. Photo: UNAMID/flickr, CC BY-NC-ND 2.0

Yet, the need for a NIEO is as critical today as it was at the time of Alma Ata. That an unfair global economic regime in reproducing the health disadvantage of poor people is clearly articulated in the report of the WHO Commission on Social Determinants of Health (Closing the gap in a generation: health equity through action on the social determinants of health. Lancet 2008). The UN Department of Economic and Social Affairs notes that since the late 1990s the net flow of financial resources from the developing economies to the industrialised economies dwarfs development assistance flows (World Economic Situation and Prospects 2008. New York). The continuing marginalization of the poor in LMICs has led to a refugee and migrant crisis and to the emergence of populist politics that threatens democracy, which is a fundamental prerequisite for PHC.

Responding to these political crises and tackling the economic forces driving this will require increased regulation of the national and global socio-economic environment and the powerful entities and structures reproducing this situation. The radical notion agreed in 1978 was that health development through 'community participation' necessarily involves action on the broader environmental and social determinants, and that PHC can catalyse such action.

However, the revitalization of CPHC is unlikely without concerted advocacy by supra-national institutions, including the WHO, for a radically changed, more equitable global economic dispensation, that also urgently addresses climate change. Such advocacy will not occur without a broad and strong global movement for health and social equity.

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