

# Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries

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The Conference strongly reaffirms that health, which is a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector — Alma-Ata Declaration, 1978.<sup>1</sup>

ACCESS TO BASIC HEALTH SERVICES was affirmed as a fundamental human right by the Declaration of Alma-Ata in 1978.<sup>1</sup> The reality is that, in 2002, more than 30 years later, many people in resource-poor settings still do not have equitable access to even basic services. In many places this gap is widening.<sup>2</sup>

## Background

The 1960s and 1970s was, for many developing countries, an era of newly won independence from former colonial powers. This independence was accompanied by an enthusiasm to provide high-standard healthcare, education and other services for the people. Governments moved to establish teaching hospitals and medical and nursing schools, often with the assistance of donor nations. These tertiary services consumed the largest portion of the country's healthcare budget, and were available mostly in urban areas, creating access problems for the predominantly rural societies. Healthcare services to the rural majority were supplied by missionary hospitals and clinics, or by "touring services" provided from urban hospitals. There was a wide variety of services of varying standard and quality in the rural areas. Most of the population still visited traditional healers.<sup>3</sup>

By the 1970s, the morbidity and mortality for rural communities was not improving, and in some places they deteriorated.<sup>3,4</sup> In places where people did have access to services, cultural beliefs about illness meant those services were not being accessed.<sup>3,4</sup>

Further developments, such as oral rehydration solutions, showed that early and appropriate intervention by carers and village volunteers could avoid referral and admission to hospital,<sup>5,6</sup> and, if combined with an effectively organised vaccination program, would address the major causes of death and illness.<sup>7</sup>

## ABSTRACT

- Access to basic health services was affirmed as a fundamental human right in the Declaration of Alma-Ata in 1978.
- The model formally adopted for providing healthcare services was "primary health care" (PHC), which involved universal, community-based preventive and curative services, with substantial community involvement.
- PHC did not achieve its goals for several reasons, including the refusal of experts and politicians in developed countries to accept the principle that communities should plan and implement their own healthcare services.
- Changes in economic philosophy led to the replacement of PHC by "Health Sector Reform", based on market forces and the economic benefits of better health.
- It is time to abandon economic ideology and determine the methods that will provide access to basic healthcare services for all people.

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In the 1960s and 1970s, China, Tanzania, Sudan and Venezuela initiated successful programs to deliver a basic but comprehensive program of primary care health services covering poor rural populations.<sup>3,4</sup> From these programs came the name "primary health care". Papua New Guinea had a similar comprehensive program in place for some years.<sup>8,9</sup> This new methodology for healthcare service delivery incorporated a questioning of top-down approaches and the role of the medical profession in healthcare provision.

During the 1970s, a synthesis of these concepts was undertaken by the World Health Organization (WHO) and UNICEF. It addressed the need for a fundamental change in the delivery of healthcare services in developing countries, with an emphasis on equity and access at affordable cost, and emphasising prevention while still providing appropriate curative services. This took place in an era where the pre-eminent role of government in the provision of health, education and welfare services was taken for granted in most developed countries, and when there still existed large countries with socialist economies, such as the USSR and China.

## The Foundations of Primary Health Care: Alma-Ata

The Declaration of Alma-Ata formally adopted primary health care (PHC) as the means for providing a comprehensive, universal, equitable and affordable healthcare service

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for all countries. It was unanimously adopted by all WHO member countries at Alma-Ata in the former Kazak Soviet Republic in September 1978.<sup>1</sup>

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process — Alma Ata Declaration, 1978.<sup>1</sup>

PHC envisaged universal coverage of basic services such as education on methods of preventing and controlling prevailing health problems; promotion of food security and proper nutrition; adequate safe water supply and basic sanitation; maternal and child health, including family planning; vaccination; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. The emphasis changed from the larger hospital to that of community-based delivery of services with a balance of cost-effective preventive and curative programs. The approach was intersectoral, involving agriculture extension officers, schoolteachers, women's groups, youth groups and ministers of religion, etc. The community, through its leaders, was to be involved in the planning and implementation of its own healthcare services through community Primary Health Committees. Where Western-trained doctors and nurses were not available, Village Health Workers were to be trained and used as a formal part of the healthcare system.<sup>10</sup>

The conference went so far as to address the economic and political steps needed to fund the initiative:

An acceptable level of health for all people of the world by the year 2000 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 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 — Alma-Ata Declaration, 1978.<sup>1</sup>

National governments throughout the world adopted PHC as their official blueprint for total population coverage with essential PHC services. Goals and targets were set for Achieving Health For All by the Year 2000.<sup>10</sup> Some of these goals were that:

- at least 5% of gross national product should be spent on health;
- at least 90% of children should have a weight for age that corresponds to the reference values;

- safe water should be available in the home or within 15 minutes' walking distance, and adequate sanitary facilities should be available in the home or immediate vicinity;
- people should have access to trained personnel for attending pregnancy and childbirth; and
- child care should be available up to at least one year of age.

In the initial stages, nurses and health extension officers (who had skills allowing them to undertake procedures previously the domain of doctors) were trained to work in community health centres, which covered the population. They were given balanced training in clinical and preventive PHC interventions. Where there were gaps in the healthcare system, village health workers were trained in a limited number of skills to fill these gaps. Community representatives, through Village Primary Health Care Committees, were supposed to have a central role in planning and overseeing their healthcare services.<sup>10</sup> Adequate supervision to ensure service quality, essential drugs, vaccines and equipment, especially at the most peripheral levels, was envisaged.

Almost as soon as the Alma-Ata Conference was over, PHC was under attack. Politicians and aid experts from developed countries could not accept the core PHC principle that communities in developing countries would have responsibility for planning and implementing their own healthcare services. A new concept of "Selective Primary Health Care" (SPHC)<sup>11</sup> advocated providing only PHC interventions that contributed most to reducing child (< 5 years) mortality in developing countries. The advocates of SPHC argued that comprehensive PHC was too idealistic, expensive and unachievable in its goals of achieving total population coverage. By focusing on growth monitoring, oral rehydration solutions, breastfeeding and immunisation, greater gains in reducing infant mortality rates could be achieved at reduced cost.<sup>11</sup>

In effect, SPHC took the decision-making power and control central to PHC away from the communities and delivered it to foreign consultants with technical expertise in these specific areas. These technical experts, often employed by the funding agencies, were subject to the policies of their agencies, not the communities. SPHC reintroduced vertical programs at the cost of comprehensive PHC.<sup>12,13</sup>

The PHC versus SPHC debate continued throughout the 1980s.

There were other reasons why PHC did not achieve Health For All by the Year 2000.<sup>14</sup>

- Many ordinary people felt PHC was a cheap form of healthcare and, if they were able to, they bypassed this level to attend secondary and tertiary centres because of a lack of staff and essential medicines at the PHC level.
- Civil war, natural disasters and, more recently, HIV affected the ability of PHC to maintain comprehensive services, especially in many sub-Saharan countries.
- Political commitment was not sustained after the initial euphoria of Alma-Ata. In many cases PHC became a jargon term used as a slogan, and little else. The rhetoric was not backed with the necessary reforms.<sup>14</sup> Agencies were content if countries adopted PHC as a policy, and did not assess

actual practice. Politicians saw PHC as a way to reduce expenditure in health and lacked the political will to ensure that services were equitably shared and distributed. Most healthcare resources continue to be directed to the large urban-based hospitals.

■ Issues of governance and corruption in the use of resources resulted in donors becoming very wary of funding comprehensive, broad-based programs. Vertical, definable, time-limited programs that could be changed every few years suited both donor agencies and governments.

### Health Sector Reform: The World Bank Report, 1993

Changes in political and economic philosophy in the late 1980s and 1990s marked a major change in how government services were delivered throughout the world. These reforms had their roots in the economic reforms of North America and Europe. Emphasis was placed on reducing government involvement in all aspects of society. Market forces became the dominant model for service delivery.

The fall of the socialist eastern European bloc and China's adoption of many aspects of liberal economics were major features of this period.

Governments in resource-poor countries, which had already reduced their expenditure on health as their foreign debt mounted in the 1980s and 1990s, now had to contend with the new economic philosophy. International donors insisted these governments adopt the market-driven economic reforms if they were to receive foreign aid and debt relief.

It was against this background that the World Bank's World Development Report of 1993, "Investing in Health", was undertaken.<sup>15</sup> It reflected a marked change in the orientation of how healthcare services in resource-poor countries would be delivered. The report makes little use of the term "Primary Health Care". It considers the delivery of healthcare services in terms of the economic benefit that improved health could deliver, and sees health improvement mainly in terms of improvement of human capital for development, rather than as a consequence and fruit of development. The report is mostly about healthcare sector activities in improving health, and gives scant recognition to the role of other sectors, which contrasts with the original PHC's multisectoral approach.

This World Bank approach became known as Health Sector Reform. This heralded an emphasis on using the private sector to deliver healthcare services while reducing or removing government services. User pays, cost recovery, private health insurance, and public-private partnerships became the focus for delivery of healthcare services. Although the report does discuss in detail the issues of market failure, externalities, inequity and the importance of public goods, its conclusions fail to fully reflect these concerns in matters of policies and recommendations. How these reforms are implemented in situations of absolute poverty and to indigent populations is not explained.

Further, Health Sector Reform was and is seen in developing countries as being imposed by economists from North America and Europe. As a policy it has not been debated

### Case study: the Gambia<sup>18</sup>

In the Gambia, in west Africa, a study by the United Kingdom Medical Research Council of 40 villages beginning in 1981 over a 15-year period compared infant and child mortality between villages with and without primary health care (PHC). Extra services to the PHC villages included a paid Community Health Nurse for about every five villages, as well as a Village Health Worker and a trained Traditional Birth Attendant. Maternal and child health services with a vaccination program were accessible to residents in both PHC and non-PHC villages. There were marked improvements in infant and child (<5 years) mortality in both PHC and non-PHC villages.

After the establishment of PHC in 1983, infant mortality in the PHC villages dropped from 134/1000 in 1982–1983 to 69/1000 in 1992–1994, and from 155/1000 to 91/1000 in the non-PHC villages over the same period. The change in death rates for children aged 1–4 years between the two groups was not as marked.

Supervision of the PHC system weakened after 1994, and infant mortality rates in the PHC villages rose to 89/1000 in 1994–1996. The rates in non-PHC villages fell to 78/1000 for the same period. Mortality rates rose significantly when PHC services were weakened.

and unanimously agreed to, as PHC was at Alma-Ata. Communities in developing countries do not have a say directly or indirectly in their health services. There is no sense of this new approach promoting equity in accessing even the most basic of services, let alone the benefits of modern medical advances. Rather, there is a sense of inequity, marginalisation and frustration.

Since the 1993 report, the World Bank and other similar agencies have made little reference to PHC as endorsed at Alma-Ata. WHO continued to use the terminology throughout the 1990s. It conducted reviews and held meetings<sup>16</sup> assessing and attempting to strengthen progress towards Health for All by the Year 2000.

The "World Health Report 2000, Health Systems: Improving Performance" marked the end of WHO's use of PHC as the means for the delivery of healthcare services in resource-poor countries. This report puts the failure of PHC to achieve its goal down to inadequate funding and insufficient training and equipment for healthcare workers at all levels. This resulted in either a total lack of services at the community level, or services of such poor quality that people had no option but to bypass the primary-level providers, resulting in a failure of the referral system within the PHC hierarchy.<sup>17</sup>

But what has been the basis for abandoning PHC other than a change in economic and political philosophy? As the study from the Gambia shows (Box),<sup>18</sup> PHC does bring about reductions in infant mortality when implemented with sufficient resources. Further, worldwide vaccination coverage rates for measles have risen from less than 20% in 1980 to now cover 80% of the world's population, and measles cases have fallen from more than four million in 1980 to be now less than 0.8 million annually.<sup>19</sup> There is strong evidence that infant mortality rates in resource-poor countries have continued to drop at a steady rate since 1990.<sup>20</sup> There are strong indications that PHC has and can bring about marked gains in health.

## The future: health beyond 2000

Given the enormous economic and political sway of the World Bank, the Health Sector Reform methodology will continue in the immediate future as the vehicle for health-care service delivery, especially in countries having structural adjustment programs imposed on them

However, this is not unquestioned. Health Sector Reform is criticised as being driven by economic and political ideology.<sup>13</sup> There is little provision for ensuring equity in access to services, especially for people living in absolute poverty or the indigent. As Whitehead et al point out, "The actual outcomes of previous and current market-oriented reforms have often been contrary to stated objectives, as economic access for poor people has declined and total costs have increased".<sup>21</sup> Ten years on, is it not time that Health Sector Reform also underwent thorough review?

Advocates of PHC are drawn largely from non-government organisations, academics and community groups within developing countries who argue that PHC was not given a chance to establish itself as a viable system or methodology.<sup>22</sup> Once the economic and political implications of the Alma-Ata Declaration were recognised, it was not given a chance to survive politically or economically.

A reasonable criticism of PHC is that it did not establish whether it was actually bringing about a quantifiable change in the health of populations in the early 1990s. Its data, analysis and evaluation systems were weak at a time when there was a demand for evidence-based demonstrations in health status. But was this sufficient reason to stifle a methodology that gave a sense of participation in and equity of access to a healthcare service over which communities had some control?

## Conclusion

As the world reviews healthcare services beyond 2000,<sup>23</sup> work continues on reducing health inequities for poor people. Concern is being expressed that people living in absolute poverty still do not have access to basic services or a healthy environment.<sup>2</sup> As economic development improves the incomes and standards of living in many developing countries, an increasing gap is opening up between the rich and the poor and this is associated with inequitable access to healthcare services. There are now calls to give "voice" to the poor so they have a greater say in how healthcare services are delivered.<sup>24</sup> But, then, isn't this PHC?

Further, as we reflect on recent world events, surely we must address the underlying causes. The United States is prepared to spend \$US100 billion on a war in Iraq,<sup>25,26</sup> but only contribute \$US200 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria. If those funds were expended on the provision of an equitable and comprehensive PHC system and the relief of the massive debt burden, this would be a major step in addressing the prevailing sense of frustration in resource-poor countries.

It is time to put political and economic ideology aside and determine the methodology that will yield the greatest gains and provide access to even the most basic of services for All People Beyond the Year 2000.

## Competing interests

None identified.

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