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Alma Ata after 40 years: Primary Health Care and Health for All—from consensus to complexity

Susan B Rifkin

ABSTRACT

Forty years ago, the 134 national government members of the WHO signed the Alma Ata Declaration. The Declaration made Primary Health Care (PHC) the official health policy of all members countries. Emerging from the conference was the consensus that health was a human right based on the principles of equity and community participation. Alma Ata broadened the perception of health beyond doctors and hospitals to social determinants and social justice. In the following years implementing this policy confronted many challenges. These included: (1) whether PHC should focus on vertical disease programmes where interventions had the most possibility of success or on comprehensive programmes that addressed social, economic and political factors that influenced health improvements; (2) whether primary care and PHC are interchangeable approaches to health improvements; (3) how equity and community participation for health improvements would be institutionalised; and (4) how financing for PHC would be possible. Experiences in implementation over the last 40 years provide evidence of how these challenges have been met and what succeeded and what had failed. Lessons from these experiences include the need to understand PHC as a process rather than a blueprint, to understand the process must consider context, culture, politics, economics and social concerns, and therefore, to recognise the process is complex. PHC needs to be examined within evaluation frameworks that address complexity. Recent developments in monitoring and evaluation have begun to respond to this need. They include realist evaluation and implementation research.

London School of Hygiene and Tropical Medicine, London, UK

Correspondence to
Dr Susan B Rifkin;
sbrifkin@gmail.com

Summary box

► The Alma Ata Declaration in 1978 expanded the approach to improving health for all people from the focus on doctors, hospitals and biomedical advances to include human rights, concern for equity and community participation.
► To pursue this goal, the member nations of the WHO committed their governments to accept Primary Health Care as their national policy.
► Implementing this policy proved to be challenging focusing on issues including whether action should focus on vertical disease programmes or holistic health programmes, how to define and pursue community participation and equity and how to finance PHC programme.
► A major concern was how to asses PHC interventions as experiences showed that implementation was contextual and not generalisable in great part because people did not behave the way professionals thought they should.
► Evidence suggests PHC needs to be understood as a process in the framework of complex interventions that consider not only outcomes/impact also why and how an intervention works/ does not work.

INTRODUCTION

Traditionally, over the last two centuries, health has been defined as hospitals and doctors. While in the past there has been a recognition of the importance of health as a reflection of social determinants, in 1978, this recognition was formalised into policy. The 134 member states of the WHO declared good health was also the result of factors that included access to services, education, social and economic status and political and individual choices. The Alma Ata Declaration stated 'Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care' (p. 3).[1]

The Declaration supported by all member states of WHO put forward a new policy titled Primary Health Care (PHC) defined as '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 that the community country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination'[1] (p. 3). Raising challenges to a view of health dominated by biomedicine and the medical profession, the policy gave a new context declaring health as a human right

supported by the principles of equity and community participation. In the ensuing years, it faced the challenge of implementing this policy in the light of traditional view of health and by a growing acceptance of neoliberal economics that moved health care from a public good to a consumer product.

The purpose of this paper is to trace the history of PHC policy from its inception up to the 40th anniversary of the Alma Ata Declaration in 2018. It is a history that started with a consensus of the United Nations agencies supporting a view of health as a human right and as a result of social determinants to a narrower view defining universal health coverage (UHC) as a focal point of policy implementation. This paper argues that one major reason for the challenge to translate the PHC vision from rhetoric into reality was the failure to understand and act on the complexity of implementation. There was underlying but unstated assumption that PHC was a blueprint rather than a process for universal health improvements.

OVERVIEW OF PHC HISTORY

The historical development of PHC is complicated and complex.[2] The Alma Ata Declaration was accepted in a period that reflected the commitment of several countries, including those devastated in World War II and those that had relinquished their former colonies, to address the injustices of the prewar period. Their commitment created the United Nations and a search for social justice, particularly in 'developing countries' that were gaining independence from their colonial masters. In the 1970s, the United Nations promoted the idea of a New International Economic Order to pursue this goal.[3]

However, implementation of the idealism of this period was sorely stretched by the existing frameworks of policy and financial commitments that lacked capacity and will to address equity and redistribution of resources. These limitations were illustrated in the following period with the 1982 oil crisis. With governments reverting to debt collection from the low-income and middle-income countries, a policy of structural adjustments followed in these countries. The reasons for the structural adjustment policies are convoluted and complex. A good investigation of these factors can be found in an article by Labonté and Stuckler.[4] Essentially, the World Bank and International Monetary Fund gave substantial loans to the 'developing countries' with strict conditions about use and repayment. The assumption that these countries would continue economic growth and would repay that debt proved to be unrealistic. This situation led to the fear of sovereign debt defaults by debtor countries and a call by the lending institutions for debt reduction and repayment. The result was reduction in social policies in affected countries and a major decrease in funding for the health and education sectors.[5]

The World Bank's 1993 World Development Report entitled 'Investing in Health' further challenged the financing of health programme that came out of Alma Ata.[6] Providing a platform for neoliberal economic strategies in the health sector, the report stressed cost-effectiveness as key to improving health care delivery and argued for a reduced role for the state in health care provision. It also earmarked substantial financial support to the health sector to carry out its recommendations. WHO, which shepherded PHC policy, responded by examining costs and effectiveness in the World Health Report 2000[7] entitled 'Health Systems: Improving Performance'. The focus on health improvements became more siloed in 2000 with the publication of the United Nation's Millennium Development Goals (MDGs) focusing on disease cure and prevention.[8] Global health policy could be seen as a shift from a comprehensive PHC approach that included the social determinants to a vertical disease-focused agenda. These documents did not address the PHC values of social justice, equity and community participation.

After a period of languishing in the shadow of financial concerns for health focusing on service delivery, in 2008, PHC once again came to the top of the health agenda with two reports from the WHO. The first, 'Primary Health Care: Now more than Ever' called for reforms that included: (A) UHC to improve health equity, (B) health service delivery reforms to make health systems more people centred; (C) leadership reforms to improve the accountability of health authorities; and (D) public policy reforms to promote and protect the health of communities.[9] The second report published by the WHO Commission on the Social Determinants of Health gave evidence that social determinants including income, education, daily living conditions and the social, the economic and political context of countries were critical to health improvements. Social justice and equity prominently returned to the global health policy agenda with the statement on the back cover of the report stating, 'Reducing health inequities is, for the Commission on Social Determinants of Health, an ethical imperative. Social injustice is killing people on a grand scale'.[10]

However, in the same year, another global financial crisis once again prioritised the provision of health services and a focus on hospital curative care[11] over the reorientation of health to pursue PHC values. In addition, new actors with financial support for vertical health programmes including the Bill and Melinda Gates Foundation, the Global Alliance for Vaccines and Immunization and the Global Fund to Fight AIDS, Tuberculosis and Malaria with much more money than WHO increasingly influenced the direction of global health policy. Their concerns overrode concerns of the PHC vision of health as a human right. In face of the changing context, WHO began to focus on a single programme that reflected concerns of equity, that of UHC. Starting with the World Health Report for 2010[12] by 2017 with a new director-general, Tedros Ghebreyesus, UHC became the mantra for WHO with equity and human rights as its foundation. This focus was reflected in Goal 3 of the

Sustainable Development Goals and in Tedros' vision for the future of WHO.[13]

CHALLENGES TO IMPLEMENTING PHC
The search for a standard implementation protocol
The broad definition of PHC in Alma Ata provoked an almost immediate challenge.[14] In an article in the *New England Journal of Medicine* in 1979, Walsh and Warren put forward the idea of Selected Primary Health Care (SPHC). It stated that PHC was clearly a compelling view about how health improvements should be pursued. However, it was too visionary to be practical. To address the concerns put forward in Alma Ata, the article argued that a SPHC approach was more appropriate. This approach focused on tackling the diseases that had the highest prevalence, the greatest risk of mortality and the highest possibility of control in terms of cost effectiveness. It challenged the view of Comprehensive Primary Health Care (CPHC) that highlighted health as wholistic based on the original definition of health by WHO (health is a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'[15])and the importance of equity, community participation and multisectoral collaboration.[16] This debate remains a point of contention among health policy planners and managers today. It focuses on whether services should be delivered in a vertical manner focusing on specific diseases or in a horizontal manner to include concerns about social determinants.[17] One way that has been put forward to resolve this apparent conflict is the call for diagonal programmes to integrate both approaches.[18]

PHC versus primary care
The term used for the Alma Ata vision for global health improvements was PHC. Accepted by those who signed the Alma Ata Declaration, it quickly caused confusion among those who sought to implement this approach. Universally supported in theory, in practice, mainly in the industrial countries, the vision was translated as primary, or first line, provision of health services. In the USA, Dr Starfield from Johns Hopkins University advocated an approach to 'provide entry into a health service that addresses all new needs and problems by giving person focused care over time, by providing care for all but unusual problems and by coordinating care provided outside the service where the person was being treated' (p. 9).[19] She noted that this approach reflected the provision of health care delivery in the industrial countries where hospital care and technology had a firm basis and where there was little experience in community-based care.

In an attempt to clarify the relationship of PHC to primary care, the Commission on the Social Determinants of Health included this statement in its 2008 report:

> The Alma Ata declaration promoted PHC as its central means towards good and fair global health—not simply

health services at the primary care level (though that was important), but rather a health system model that acted also on the underlying social, economic and political causes of poor health (p. 33).[10]

The reality, however, is that in industrial countries, as Starfield described, primary health is often equated with PHC. This situation continues to challenge the way health care is conceived and delivered both in these countries and in low-income and middle-income countries where industrial countries provide substantial monetary aid and thus influence for developing health care systems.

Evaluation of health care interventions
Rooted in the health care system, policy planners, managers, service providers and intended beneficiaries often see PHC programme as solely interventions to improve health status. As a result, their successes and failures are assessed using the same framework used for assessing biomedical interventions—the randomised control trials (RCTs). However, research studies have highlighted the weaknesses in this approach.[20–22] The assessment of intervention using RCTs is based defining a linear process that is generalisable and predictable. As PHC is people centred and people do not behave the way planners think they should, outcomes are not predictable and generalisable. They are contextual, based in history and experiences outside health care and the result of a change of attitudes and behaviours over time. For this reason, identifying replicable outcomes has been difficult and has challenged funders of health care programmes who depend on RCTs to justify their support. The following sections explore this challenge in terms of evaluating the contribution of equity and community participation to health improvements and in justifying financing for PHC programmes.

The search for equity
While accepting equity as a key principle of PHC, assessing its impact has proved elusive. Evaluators use a default measurement of inequality to investigate how the impact of health provision affects different populations. However, inequality is not the same as inequity. Inequity is an ethical concept based on social justice and linked to human rights.[23] Inequality is only descriptive of which groups have better health disregarding factors such advantages people have due to their place in the social hierarchy and access to good health based on factors such as income, education, environment and health services and health care. While inequality can tell which groups have worse health conditions, it does not answer the reason for these conditions. The Commission on the Social Determinants of Health (2008) in its third recommendation highlighted for the need to measure and understand the causes of poor health beyond health services and health care and to correct the recognised problems (p. 2).[10] Causes of inequity are not easily identified and often need proxy

measures. WHO made available in 2013 a handbook using the measurement of health inequalities as an indirect means by which to assess health inequities. It published a list of factors to consider. Referred to by the acronym PROGRESS, these factors include Place of residence (urban, rural and so on), Race/ethnicity, Occupation, Gender, Religion, Education, Socioeconomic status and Social capital or resources.[24]

The contribution of community participation

Providing data that support the contribution of community participation to health proved to be even more challenging. First, there are no standard definitions for either 'community' or 'participation'. In the health literature 'community' is often defined within geographic borders assuming a homogeneity of share interests. Yet common sense and experience confirms people living in the same area most often have different backgrounds, views and commitments.[25] 'Participation' has often been defined on a spectrum that ranges from having community people turn up at a meeting for a discussion of health topics to community people becoming part of the decisions about how health programmes are created, implemented and financed (empowerment).[26] Second, participation in health programmes has been based on a number of unproven assumptions. These include: programmes can be created and implemented without clearly defining 'community' and 'participation'; the provision of information ensures that people information will change their attitudes and behaviours; people want to be involved in decisions about their own health care; and participation will empower people to act in the way professionals know will bring about health improvements.[27 28]. Third, the evidence to support the contribution of participation to development projects including health has not been robust. The World Bank commissioned a review to investigate the contribution of participation in development projects including health. The conclusion was that the money which the Bank invested in participation, over $85 billion over the period 2003–2013, was 'arguably still driven by ideology and optimism more than by systematic analysis, either theoretical or empirical' (p. 3).[29] Finally, it has been shown that community participation in health has not addressed questions around power and control, a key to the emphasis on the importance on empowering people in order to make health interventions sustainable and cost-effective. Much of the literature has focused on the mechanisms of community participation rather than context and process.[30] It was only in 2016 the *Bulletin of the World Health Organization*[31] published an article that concluded power must be identified in communities if the transformation to sustainable health actions and programmes is to succeed.

Financing PHC policy

As discussed in the Introduction of this paper, financing of PHC policies and programmes has continually been a challenge. Much of financing concerns have focused on approaches in the low-income and middle-income countries most often dependent on donor aid and on expanding access to health care to a large population that has been underdeveloped economically and underserved. In the period following Alma Ata, an immediate response from WHO members was to establish Community Health Workers (CHW) programmes. The Chinese experience of 'barefoot doctors' inspired these programmes. Here local people received training to deal with minor health care problems in the community and promote improved health behaviours.[32] CHW programmes have been equated with PHC giving meat to the skeleton of new health care approaches.[33] Several countries including India, Colombia and Sri Lanka created CHW programmes. The early programmes did not last long. Although seen as a way to provide cheap health care to mainly rural people, in fact, the cost of training, supervision and medical supplies proved to be expensive.[34] In addition, governments were unable to ensure safety and quality when CHWs were mainly volunteers. Because of prohibitive costs, governments balked at incorporating CHW programmes.[35] By 2006, however, it was clear that the depletion of health providers, particularly in Africa due to the HIV/AIDs epidemic was a crisis.[36] From that time, governments often with the help of international donors have vastly increased resources to train and support CHWs.

However, the financing for CHW programmes and for other PHC programmes in the low-income and middle-income countries has continued to be a challenge to PHC's principle of equity. Compared with the industrial high-income countries, these countries have not allocated as much funding to health. Many of these countries are dependent on aid from foreign donors. Between 2000 and 2009, donor aid increased at a rate of 11.3% annum. Yet between 2010 and 2015, annual contribution of donor aid dropped to 2% annually.[37] As a result, there has been increasing pressure on WHO and international donors to provide health care to a majority of people living in poverty in these countries. Responding to global concerns coming from the 2008 financial crisis as well as uneven evidence about the direct relationship between PHC and specific health improvements, policy makers began to focus on a limited intervention where clear evidence could support its value.[11] By 2018, WHO had made UHC its prime policy focus based on the call for equity and community participation. However, the ways in which equity and participation would support UHC remained vague. This focus has raised concerns from economists who are unable to figure out how governments of poor countries will raise funds. It also raised concerns among those who saw the call as a siloed programme with little room to address the social determinants of health and community involvement in specific ways.[38]

LESSONS FROM 40 YEARS OF PHC

The last four decades has seen the move of a consensus on a global health policy based on the Alma Ata Declaration to a wide range of experiences in successes and failures of policy implementation. These experiences have highlighted the complexity of translating a visionary policy into practical applications. Based on the research presented in this paper, here are the most important lessons from the 40 years of PHC experiences:

There is no 'blue print' for universal implementation of PHC policy

PHC is not a biomedical intervention that is linear and generalisable for the following reasons. Unlike programmes to eradicate specific diseases focusing on the need for specific personal behaviours such as accepting immunisations or accessing clean water, PHC addresses a range of approaches that support a change of both opinions and behaviours that only happen over a long period of time and reflect a specific context amenable to these changes. It depends on the ability of governments to raise funds, on the availability of funds for the health sector and competing interests for their allocation. It depends the availability of human resources to support health programmes and on the structures to allocate and apply these resources to specific programmes. It depends on the organisation and management of health care delivery in both government and non-government programmes. Critically it depends on politics.[39]

National governments that have established PHC as a policy focus and implemented this policy do not have the same programmes. For example, Thailand[40] has pursued PHC focused on UHC. India[41] and Ethiopia[42] have focused on CHW programmes. Brazil created Family Health Teams composed of one doctor, one nurse, one nurse assistant and between four and six CHWs.[43] Countries choose and develop programmes that best suit their context and needs. Despite obstacles and limitations, these programmes have been sustainable and have been noted as successes in getting health care to poor populations over a long time period. They do share common characteristics. The political leadership that came to govern and implement PHC policy replaced the previous leadership either by an elective process or a coup. The new leadership has been committed in both words and actions to address issues around health equity through creating access to health services for the most marginalised members of the country. They also support participation of the intended beneficiaries in choices about health care mainly through the creation of CHW programmes and/or health centre committees. They have kept the flexibility to change and address challenges that arise in the implementing the programme.

PHC policy implementation is a process that develops over time and with experience

This process involves trial and error learning from mistakes and responding with flexibility meeting problems and needs. Seeing the implementation of PHC as a process highlights the dynamics of the application of the intervention. It highlights the factors that encourage or limit the its acceptance or rejection. It demands a recognition and investigation into both intended and unintended outcomes. It demands a continual monitoring of what works and why and how it works. It also demands a continual interaction between policy makers, programme managers, health providers, intended beneficiaries and other stakeholders such as non-government organisations and community people. Where programmes have made achievements health outcomes have not only been seen in statistics about health improvements. They are also seen in sustainable health programmes particularly at the community level that have been able to address issues around equity and community acceptance, involvement and support for health improvements and health care delivery.[2]

The process is complex

It must be examined within assessment frameworks designed to investigate complex health interventions. Complexity research is a growing field that responds to this need. This type of research highlights a way in which science can be used to solve the relevant problem using the relevant method. It comes from a realisation that to apply science is to confront the challenge that its application to society is not predictable and manageable with accuracy and precision. Traditional reductionist approaches that take apart a complex problem and try to deal separately with each component part fail to account for the interconnection of those parts to each other. What is needed is an alternative way of understanding the problem using alternative tools, techniques and approaches.[44] This approach is necessary to understand how why and where PHC policy has been effective and where it has failed.

Recent years have seen the creation of evaluation frameworks that respond to this need. The Medical Research Council in the UK has developed a framework for assessment of complex interventions that it defines as those with many interacting components that require some flexibility to implement and which allow for a wide range of possible outcomes relating to a variable target population.[45] However, it has been criticised because complex interventions are not predictable and cannot be reduced to a static and often mathematical model.[46] More promising is realist evaluation based on the work of Pawson and Tilley.[47] This approach uses theory-driven models that examine the context and mechanisms that underlie the intervention and produce processes and outcomes that can be observed. More recently in the field of health, implementation research has gained credence for examining

complexity. It is defined as investigating 'any aspect of implementation, including the factors affecting implementation, the processes of implementation, and the results of implementation, including how to introduce potential solutions into a health system or how to promote their large-scale use and sustainability'. Its value has been seen to examine interventions in the 'real world' to understand what works but also how and why it works.[48]

CONCLUSION

Perhaps the greatest contribution of the consensus that emerged from Alma Ata was the impetus and opportunity to explore health in a holistic approach focusing on equity, participation and the social determinants. Seeing medical interventions as necessary but not sufficient for better health for populations and individuals, PHC broadened the framework of understanding of health beyond doctors and health facilities. Where this approach has been applied despite challenges of acceptance, funding and maps for implementation, the evidence demonstrated the policy survived 40 years and enabled a second conference to take place in 2018 in Astana, Kazakhstan, to affirm commitment to the principles it advocated. PHC has gained credibility as a means to improve health status and health care for large populations particularly those who have been on the periphery of these advances in the past. For the future understanding, how this approach is best developed and used is critical both for its implementation and for resources to support expansion.

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