

# Primary health care: 30 years since Alma-Ata

The 1978 Declaration of Alma-Ata was groundbreaking because it linked the rights-based approach to health to a viable strategy for attaining it. The outcome document of the International Conference on Primary Health Care, the declaration identified primary health care as the key to reducing health inequalities between and within countries and thereby to achieving the ambitious but unrealized goal of “Health for All” by 2000. Primary health care was defined by the document as “essential health care” services, based on scientifically proven interventions. These services were to be universally accessible to individuals and families at a cost that communities and nations as a whole could afford. At a minimum, primary health care comprised eight elements: health education, adequate nutrition, maternal and child health care, basic sanitation and safe water, control of major infectious diseases through immunization, prevention and control of locally endemic diseases, treatment of common diseases and injuries, and the provision of essential drugs.

The declaration urged governments to formulate national policies to incorporate primary health care into their national health systems. It argued that attention be given to the importance of community-based care that reflects a country’s political and economic realities. This model would bring “health care as close as possible to where people live and work” by enabling them to seek treatment, as appropriate, from trained community health workers, nurses and doctors. It would also foster a spirit of self-reliance among individuals within a community and encourage their participation in the planning and execution of health-care programmes. Referral systems would complete the spectrum of care by providing more comprehensive services to those who needed them most – the poorest and the most marginalized.

Alma-Ata grew out of the same movement for social justice that led to the 1974 Declaration on the Establishment of a New International Economic Order. Both stressed the interdependence of the global economy and encouraged transfers of aid and knowledge to reverse the widening economic and technological divides between industrialized countries and developing countries, whose growth had, in many cases, been stymied by colonization. Examples of community-based innovations in poorer countries after World War II also provided inspiration. Nigeria’s under-five clinics, China’s bare-foot doctors and the Cuban and Vietnamese health systems demonstrated that advances in health could occur without the infrastructure available in industrialized countries.

The International Conference on Primary Health Care was itself a milestone. At the time, it was the largest conference ever held devoted to a single topic in international health and development, with 134 countries and 67 non-governmental organizations in attendance. Yet there were obstacles to fulfilling its promise. For one thing, the declaration was non-binding. Furthermore, conceptual disagreements over how to define fundamental terms such as ‘universal access’, which persist today, were present from the beginning. In the context of the cold war, these terms revealed the sharp ideological differences between the capitalist and communist worlds, discord perhaps heightened by the fact that the Alma-Ata conference took place in what was then the Union of Soviet Socialist Republics.

As the 1970s gave way to a new decade, a tumultuous economic environment contributed to a diversion away from primary health care in favour of the more affordable model of selective health care, which targeted specific diseases and conditions. Nonetheless, despite the mixed success of primary health care in the countries where it has been implemented, advances in improving public health illustrate the community-based model’s flexibility and applicability.

Insufficient progress towards the Millennium Development Goals, coupled with the threats posed to global health and human security by climate change, pandemic influenza and the global food crisis, have led to renewed interest in comprehensive primary health care. Yet the many challenges that prevented Alma-Ata’s implementation have evolved and must be confronted to achieve its goals now. Drawing on the growing body of evidence about cost-effective initiatives that integrate household and community care with outreach and facility-based services – such as those for maternal and child health described in Chapter 3 – will enable governments, international partners and civil society organizations to revitalize primary health care.

*See References, page 108.*