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Alma-Ata Revisited

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"Health for All by the Year 2000" was an ambitious and worthy goal. But even those who formulated it back in 1978 did not fully grasp its meaning. No wonder that 25 years later we have yet to realize all the dreams of the first International Conference on Primary Health Care.

This year marks the 25th anniversary of the first International Conference on Primary Health Care in Alma-Ata, Kazakhstan, an event of major historical significance. Convened by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), Alma-Ata drew representatives from 134 countries, 67 international organizations and many nongovernmental organizations. China, unfortunately, was notably absent.

PAHO/WHO photo

By the end of the three-day event, nearly all of the world's countries had signed on to an ambitious commitment. The meeting itself, the final Declaration of Alma-Ata and its Recommendations mobilized countries worldwide to embark on a process of slow but steady progress toward the social and political goal of "Health for All." Since then, Alma-Ata and primary health care have become inseparable terms.

A quarter century later, it is useful to look back on the event and its historical context — particularly on the theme of "Health for All" in its original sense. For one who was a direct witness to these events, it is clear that the concept has been repeatedly misinterpreted and distorted. It has fallen victim to oversimplification and voguishly facile interpretations, as well as to our mental and behavioral conditioning to an obsolete world model that continues to confuse the concepts of health and integral care with curative medical treatment focused almost entirely on disease.

Looking back

The 1970s saw the cresting of the scientific and technological revolution that began with the end of World War II, a revolution that produced, among other major changes, what is today known as globalization. But there was also a recognition of growing inequality among vast sectors of the world's population. This recognition provided the impetus during the 28th and 29th World Health Assemblies in 1975–76 for the commitment to "Health for All in the Year 2000."

Politically, the world was in a state of ideological and economic polarization, as well as a historically new form of confrontation. The Cold War was based on extraordinary technological

development on the part of the competing parties, as part of an implacable economic war whose goal was the elimination of one of the two superpowers (this would eventually happen with the fall of the Berlin Wall). But within the socialist bloc, there was also a major rivalry between the Soviet Union and China. This competition would prove decisive for the conference at Alma-Ata.

At the same time, a number of developing countries had been trying, for a number of years and in various ways, to tackle health problems with limited financial, technological and human resources. Their experiences became the subject of scholarly studies in the 1960s and 1970s, with China, India and some countries of Africa and Latin America emerging as the most often cited examples. Following the publication of some of these studies, WHO— under the leadership of Director-General Halfdan Mahler (1973–88)—responded enthusiastically. Mahler saw clearly the worth of these experiences and began to promote them around the world as the responsibility of all countries, rich and poor.

A call for action

For Mahler and others, "Health for All" was a social and political goal, but above all a battle cry to incite people to action. Its meaning, however, has been misunderstood, confused with a simple concept of programming that is technical rather than social and more bureaucratic than political.

When Mahler proposed "Health for All" in 1975, he made it clear that he was referring to the need to provide a level of health that would enable all people without exception to live socially and economically productive lives (today we would say "a minimally dignified standard of living" in a context of "truly human development"). The reference to the year 2000 meant that, as of that date, all the world's countries would have developed the appropriate political strategies and be carrying out concrete measures toward achieving this social goal, albeit within different time frames.

U.S. Senator Edward Kennedy (left) made a surprise appearance at the 1978 Alma-Ata conference. At right is then WHO Director-General Halfdan Mahler.

The process of conceptual development surrounding just what health is was also important. In 1946, the new WHO constitution incorporated a definition of health proposed by the Croatian public health pioneer Andrija Stampar. It said health was "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This was a qualitative leap from earlier concepts, but it was difficult for many government experts of the time to fully grasp its meaning.

The Declaration of Alma-Ata repeats this definition, adding that health is "a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."

Perhaps because of what might be called professional deformation, it was not really understood that health is a social phenomenon whose determinants cannot be neatly separated from other social and economic determinants. Nor can it be assigned solely to one bureaucratic-administrative sector of the state. Nor was it understood sufficiently—though it was spelled out clearly—that health is, above all, a complex social and political process that requires political decision-making not only at the sectorial level but also by the state, so that these decisions are binding upon all sectors without exception.

Something else that was quite explicit, but that remains misunderstood, is that health is the responsibility of everyone—individuals, social groups and civil society as a whole. In practice, people continued to be viewed as passive recipients of health services that emphasize curative medical treatment of specific illnesses.

The conceptualization of "primary health care" was based on erroneous and biased perceptions of the experiences of Third World countries in providing health care with limited resources. In particular, the Chinese experience with "barefoot doctors" was interpreted simplistically and superficially.

As for the concept of "care," the original term in English was translated into Spanish as *atención* rather than *cuidado*. In Spanish, *cuidado* has a much broader connotation than *atención*, implying something integral that involves horizontal, symmetrical and participatory relationships. *Atención*, in contrast, is vertical, asymmetrical and never participatory in a social sense. *El cuidado* is intersectorial, while *la atención* is the work of a single sector, an institution, isolated programs or specific services.

The term "primary" has linguistically diverse and even contradictory meanings. In Spanish, in particular, some of these are nearly opposites. *Primario* can mean "primitive and uncivilized" or "principal or first in order or degree." As a result of the simplistic and biased perceptions of the experiences on which the concept was based, it was easier, more comfortable and safer to accept the former meaning, while the spirit of Alma-Ata clearly embraced the latter. The Declaration states that primary health care "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 was never seen as an isolated part of the health care system, nor was it limited to marginal, low-cost treatment for the poor.

There is a fundamental difference between integral health care for everyone and by everyone—care that is multisectorial and multidisciplinary, health-promoting and preventive, participatory and decentralized—and low-cost (and lower quality) curative treatment that is aimed at the poorest and most marginalized segments of the population and, what is worse, provided through programs that are parallel to the rest of the health-care system without the direct, active and effective participation of the population.

In my academic activities I have repeatedly stressed this issue, attempting to point out what primary health care is not (regardless of its name, which can lead to mistaken assumptions), and what it indeed is. Repeatedly, while I was deputy directorgeneral of WHO, I was forced to keep a prudent silence when high-level officials from a given government would tell me with pride that they had a specific "office" or a "national program" for primary care, or that they had primary care activities only in the most peripheral health centers.

A Soviet proposal

It was at the 28th World Health Assembly, held in 1975, that the urgent need for new approaches to health care for everyone and by everyone was finally recognized. This is how the notion of primary health care emerged, and it was a victory for the developing world. Western powers accepted this notion, but the Soviet Union opposed it, considering it a step backward in scientific and technological progress. This showed that the "Flexnerian" model had crossed the ideological frontiers of the Cold War.

No one thought about an international conference on the subject, however, during the 28th assembly; the prevailing wisdom was that new experiences were needed in this area.

Then in January 1976, a day before the meeting of WHO's Executive Board (prior to the 29th World Health Assembly in May of that year), Dimitri Venediktov, the powerful Soviet vice-minister for international affairs in the Ministry of Health, came to see me at my home in

Geneva. He proposed holding a major international conference on primary health care and offered $2 million as an extraordinary contribution by the Soviet Union. He explained to me that the leading socialist power could not allow China a victory within the Third World. His proposal came as a great surprise, and my argument that such a conference would be premature—and that it should not take place in Moscow—did not seem to convince him.

Venediktov presented his proposal at the start of the WHO Executive Board meeting and, under considerable pressure, conceded that such a conference should take place in a developing country rather than in the Soviet capital. The idea was formally accepted four months later at the World Health Assembly, and the conference was scheduled for 1978. I was designated by the director-general as general coordinator in charge of the technical, logistical and political aspects. The task would take me 29 months and several trips to the Soviet Union and other countries.

I must acknowledge today that holding a major international conference was the right thing to do, since it might well have provided an effective way of promoting a much-needed change. In this respect, there is no doubt that my friend Venediktov was a consummate politician. The distortions of the concepts surrounding this subject were not a result of the conference; they must be attributed to a lack of promotion and follow-up on the part of the governments and international organizations that convened it.

Delegates take a break outside Alma-Ata's monumental Lenin Convention Center, with its seating capacity for 3,000 people.

Once Moscow was ruled out, the search was on for another location in the Third World to host the conference. It was a difficult task, given the economic and logistical implications of such an undertaking. There was an additional cost of slightly more than $1 million over the original $2 million offered by the Soviets. San José, Costa Rica, was discarded when U.S. support could not be secured. Cairo was also rejected when the oil-producing countries from the region failed to provide the required support. I traveled to Iran to see if Teheran might host the event, but I only managed to interest the Shah's sister, Princess Ashraf Pahlavi (she later became one of six vice-presidents of the conference). Finally, there was no other practical solution than to select a city in the Soviet Union other than Moscow.

Venediktov and I discussed possible venues and traveled together to Baku, Tajikistan and Alma-Ata. The decision had to be made by the Soviet government, and I only made a detailed chart of the minimum physical and logistical requirements. But once again my friend Venediktov taught me a lesson in political management. At all three sites he introduced me as the person who would make the final decision.

The choice of Alma-Ata was due to two fundamental considerations: the dynamism and leadership of Kazakhstan's minister of health, and the feasibility of having the required physical infrastructure ready on short notice. Alma-Ata, which means "father of the apples," was in the republic where the Soviet Union had its Cold War space programs. It was also next to China.

The work undertaken by the government and the Ministry of Health of Kazakhstan was truly extraordinary. In the space of a year, they built, among other things, a hotel with 1,000 beds. The magnificent Lenin Convention Center, with its auditorium for 3,000 people, had a simultaneous interpretation system and earphones at each seat. However, the communications system was one-way— that is, from the podium to the delegates and not vice versa—so another system had to be brought in from Italy.

Other problems were solved in the course of several trips. To facilitate immigration and customs procedures in Moscow and Alma-Ata, we flew in the entire staff of the WHO secretariat; it took two airplanes. But in the end, everything proceeded without delay. U.S. Senator Edward Kennedy, who arrived at the last minute and not as an official member of the U.S. delegation, was well received. His presence demonstrated the political importance the conference had achieved.

Working documents were prepared one year ahead of the conference. Following consultations with governments and other organizations, these became official documents for the conference's review and approval. The Declaration and Recommendations went through 18 drafts revised in meetings in the six WHO regions, in the Special Meeting of Ministers of Health of the Americas in 1977 and in meetings of special country groupings and certain individual countries as well. The conference was prepared as an open, decentralized, democratic and participatory process, though this was never formally declared.

The draft that was officially presented contained a few changes that, in hindsight, contributed to the later distortion of the original concepts. Many delegations and individual delegates fought to include details that had more to do with medical specialties than with health.

It was important that the conference was cohosted and jointly organized with UNICEF. This was difficult at the beginning, but the work done by two key UNICEF representatives, Richard Hayward and Newton Bowles, was instrumental in winning over Henry R. Labouisse, then executive director, and securing the active participation of the agency. I still consider it a privilege to have worked so closely with UNICEF and to have continued that close collaboration until my departure from WHO.

It is regrettable that afterward the impatience of some international agencies, both U.N. and private, and their emphasis on achieving tangible results instead of promoting change—something that is always difficult—led to major distortions of the original concept of primary health care. So-called "selective primary health care" and packages of "low-cost interventions," such as GOBI and GOBI-FFF (growth monitoring, oral rehydration, breastfeeding, immunization; female education, family spacing, food supplements), as well as other variations contradicted and distorted the spirit and concepts of Alma-Ata.

A new era

The conditions that led to the social and political goal of "Health for All" and to the strategy of primary health care still exist and are, indeed, even more pronounced. There remain gaping inequities and social injustice that leave large segments of the population without integral health care. Poverty is on the rise, and the few resources that societies have for education and health are invested and spent in misguided and unfair ways. The confusion between health and curative medical treatment that is focused on a few diseases inexplicably still prevails. Health systems have not been decentralized effectively, and both "citizen participation" and "social control" in health remain distorted concepts.

In today's globalized, unipolar world, where national sovereignty is increasingly threatened, one of the few ways in which countries can still control their own destiny is through the development of genuine, decentralized and participatory democracies. Nowadays it is essential to transfer, or rather, to return political power for social decision-making to its point of origin, that is, the citizenry. Integral health care for all and by all—perhaps the best way to phrase Alma-Ata's call for genuine primary health care—is a necessity not only for health but also for the future of countries that aspire to remain sovereign nation states in an increasingly unjust world.

There have been major global changes and many important new experiences in the world during the 25 years since the first International Conference on Primary Health Care. Perhaps it

is time now to convene an Alma-Ata II, to set forth again, without distortions, the original concepts that led to that conference in 1978.

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Key conclusions

The final Declaration of Alma-Ata contained 10 principal points, which are summarized below. The full text of the document can be viewed here.

I. Health is a state of complete physical, mental and social well-being and is a fundamental human right. Attaining the highest possible level of health is a worldwide social goal that requires the action of many sectors.

II. The existing gross inequality in people's health status is unacceptable and is of common concern to all countries and people.

III. Economic and social development is essential to attaining health for all, and health is essential to sustained development and world peace.

IV. People have the right and duty to participate in planning and implementing health care.

V. A main goal of governments and the international community should be the attainment by all peoples by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this goal.

VI. Primary health care is 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. It is the central function of the health system and its first level of contact, bringing health care as close as possible to where people live and work.

VII. Primary health care evolves from a country's own conditions and addresses the main health problems in the community. It should lead to progressive improvement of health care for all while giving priority to those most in need.

VIII. Governments should formulate policies and plans of action to make primary health care part of a comprehensive national health system, in coordination with other sectors. This requires political will to mobilize domestic and external resources.

IX. The attainment of health in any one country directly concerns and benefits every other country. All countries should cooperate in the development and operation of primary health care throughout the world.

X. An acceptable level of health for all people by 2000 can be attained through better use of the world's resources, much of which is spent on military conflict.

"The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community…to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration."