Editorial

Primary Health Care in London: onwards from Alma Ata

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Modern primary health care was born 30 years ago, in September 1978, at a conference in Alma-Ata, then the capital of Kazakhstan in the former USSR. One hundred and thirty four member states of the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF), and 67 international organisations reached consensus about how to ensure 'Health for All by the Year 2000'. Building on earlier work by Lalonde¹ on the wider determinants of health the legendary Halfdan Mahler, WHO Director General, led the development of a landmark declaration. It included a set of ten shared values and guiding principles for comprehensive primary health care² (Box 1).

The Alma-Ata declaration defined primary health care as

'... essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.'

The loss of a horizontal dimension

There was a lot of enthusiasm for this audacious vision. Expectations were high. But political support in the West was weak – partly because there was still the Cold War. But perhaps more pertinently, the principles enunciated in the declaration were at odds with the neo-liberal economic and health policies being advocated by many western governments in the 1980s and early 1990s. The declaration itself was also misunderstood by many; some in the developing countries considered the emphasis on 'appropriate technology' tokenistic whilst many in the developed countries considered it an attack on the established medical model of curative care. Later unprecedented global events

such as the HIV pandemic, resurgence of drug resistant TB and Malaria, and the global economic crisis of the 1980s also conspired to redirect effort away from combined horizontal and vertical ideals of 'comprehensive primary health care' towards unbalanced vertical, disease focused programmes. So the enthusiasm and high expectations would be followed by disappointment. The goal of Health for All by the Year 2000 would not be met.

Alma-Ata did produce many positive results. Modest successes were recorded in the coverage of the focused targets of childhood immunisation and access to water and sanitation in the developing countries. However, the broader 'horizontal' ambition to engage whole communities in the promotion of whole society health was diluted and moved forwards in a patchy way. The UK did better than other countries. The declaration's focus on social determinants of health was followed in the UK by the Black Report on Health Inequalities in 1980,³ the Whitehead Report in 1987^{4,5} and then the Acheson Report of 1998.⁶ These influential reports changed the landscape of UK health policy by bringing health inequalities to the top of the policy agenda. The emphasis on health promotion was followed by the Ottawa Declaration in 1986⁷ which has influenced the current approach to health promotion and social marketing. Alma-Ata also influenced the introduction of targets in health policy. In 1980 33 member states of WHO Europe agreed a set of 35 targets and 65 indicators for monitoring progress towards Health for All by the Year 2000. This initiative was evaluated in 1985⁸ and by mid 1990s target setting had become a feature of major UK National Health Service (NHS) white papers.^{9, 10}

The spirit of Alma-Ata was also evident in the Millennium Declaration in 2000. In September 2000 189 Heads of State gathered to set yet another set of eight goals, most of which had their origins in various United Nations conferences that followed the Alma-Ata declaration. The Millennium Development Goals (MDGs)¹¹ aimed to eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality

Box 1 Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978**Declaration:****I**

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.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, 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. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world 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 target as part of development in the spirit of social justice.

VI

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 that 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.

VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

Box 1 Continued

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country.

X

An acceptable level of health for all the 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.

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and empowerment for women, reduce childhood mortality, improve maternal health, combat HIV/AIDS, Malaria and other diseases, ensure environmental sustainability and develop global partnerships for development by 2015. Whilst these ideals had been envisioned in 1978, the horizontal dimension originally agreed at Alma-Ata to be essential to their achievements was now completely ignored in favour of vertical approaches. Almost entirely, the MDG approach focuses on disease based programmes, such as the Global Fund to Fight AIDS, TB and Malaria (GFATM) and Global Alliance for Vaccines and immunisation (GAVI). Presently most developing countries are off track and unlikely to meet their targets.

Resurgence of combined horizontal and vertical approaches

The failure of vertical disease focused programmes, the increasing literature evidence on the central role health systems play in ensuring better health outcomes^{12–16} and the emergence of new global partnerships that focus on health system strengthening have once again focused attention on integrated and comprehensive primary health care as the strategy that is best suited to deliver better health outcomes both at national and international levels. The current WHO

Director General, Margaret Chan, is now committed to the ideals of strengthening primary care advocated at Alma-Ata. The WHO Commission for Social Determinants of Health in their report of August 2008 strongly endorses a return to the strategy of comprehensive primary care systems.¹⁷ The 2008 World Health Report¹⁸ was launched on the eve of the 30th anniversary of Alma-Ata in an effort by the WHO to further signal its renewed support for a focus on primary health care. The report is aptly titled *Primary Health Care – now more than ever*. It focuses on issues such as fair access to services, service efficiency, meeting the needs of service users and disadvantaged groups in society. These themes will be familiar to anyone involved in delivering primary care services in London today.

The future of generalist primary care in London

So how relevant is a return to the principles of Alma-Ata likely to be for London general practice and primary care services?

The on-going reforms of London primary care services closely follow the script written down 30 years ago in Alma-Ata. Health inequalities are still top of the agenda in Lord Darzi's Health Care for London (HfL)

reforms. Reducing health inequalities is a key target in the NHS London World Class Commissioning (WCC) programme, which aims to ‘add life to years, and years to life’ – words borrowed from the Ottawa Declaration on Health Promotion.⁷ Primary Care Trusts (PCTs) and Practice Based Commissioning (PBC) groups have to develop skills to commission for Health and Wellbeing. Increasing emphasis is given to integrated preventive programmes.

The renewed emphasis on integrated primary health care and appropriate technology is evident in the proposals for polyclinics across London. Referral quality and systems are improving with developments in information technology and several referral management schemes. The polyclinic debate continues to divide opinions. But the Lord Darzi interview for the first edition of the *London Journal of Primary Care* clarified that polyclinics are meant to be less about buildings, and more about the organisation of health care systems. Primary care and community services MUST seamlessly link together, and with secondary care. The increasing emphasis on integrated primary care services will call for a greater need for the gate-keeping role of General Practitioners (GPs) because patients will need to be informed and encouraged to use a range of services provided by pharmacists, dentists, nurse practitioners, specialist nurses, therapists, other primary care staff and of course by GPs with special interests.

Many primary care practitioners in London will also be familiar with issues around human rights and social justice in health care provision, not least because of the extra burden of providing services for refugees, traveller communities and other hard-to-reach groups. Health tourism is also a recent but increasing problem within metropolitan London – solutions are likely to be found in primary care. Many PCTs are developing or reviewing their Single Equalities Schemes in order to comply with the law on a range of equality issues ranging from age, sex, sexual orientation, religion, ethnicity, disability and culture. Primary care providers will be expected to be aware of the Schemes and to comply with them.

Community participation and user involvement were key principles agreed in Alma-Ata. GPs are familiar with patient evaluation of their services, but seeking the views of patients and communities when developing whole services is relatively new. Nevertheless this still needs to be embedded in the routine business of PBC. The recent HfL public consultations show something of future models. The literature on community participation suggests that the empowerment model advocated by activists may be more acceptable in the current political climate than the utilitarian model of community participation often advocated by pragmatists.¹⁹ Perhaps GP Trainers should teach this to their trainees. The paper by Chung and McKendrick on participation, equity and inter-se-

toral collaboration in Vauxhall Primary Care Centre in Liverpool provides an example that London general practices could emulate.

Improving access to care is another service imperative in the current reform of primary care services. For practitioners in London, this will usually revolve around waiting times, waiting lists, and the 18 week targets. Financial barriers to access are fortunately not an issue for UK primary care but geographic barriers are important, and primary care practitioners in London will increasingly be required to ensure that their premises are Disability and Discrimination Act (DDA) compliant.

The Alma-Ata focus on inter-sectoral cooperation and partnership working is also pertinent to London primary care in areas such as the increasing prevalence of diabetes, obesity, smoking, sexual health, drugs and alcohol problems. Tackling these health problems will require coordinated effort and policies, most of which will be outside the health care sector. London primary care will need to engage with local authorities, schools, the third sector and small businesses in local health economies in order to effectively confront these challenges.

This edition of the *London Journal of Primary Care*

This edition of the *London Journal of Primary Care* is dedicated to the lessons from Alma-Ata from a variety of perspectives. The paper by Wong and colleagues uses a case study from the Chinese health reforms to illustrate a key statement in Alma-Ata – that primary health care evolves from the economic, socio-cultural and political characteristics of a country. The paper traces the evolution of traditional family doctor role to the current focus on multidisciplinary teams working in primary care, and concludes that a focus on holistic care and people, as well as diseases, will strengthen healthcare systems and ensure that general practice remains relevant in the 21st century. The papers by Illife, Peters, and Chung and McKendrick all address the issue of joint working for better health outcomes from different perspectives, while Singh in his reflections on Alma-Ata and 60 years of the NHS, raises important ethical, equity and resource allocation tensions in today's health services. He makes the point that the social model of care does not deny curative care.

Three papers provide an international perspective to this Alma-Ata edition:

- Harries in his paper *The best is the enemy of the good*, recounts experiences from more than 20 years in Sub-Saharan Africa and argues that it is better to

provide a good service to as many people as possible rather than focus on a top-class service for a few. In other words, horizontal equity is at least a worthy pursuit in healthcare delivery as vertical equity.

- Carelli describes how WONCA and EURACT are adapting the model espoused in the Alma-Ata declaration in training future generations of GPs/family doctors in continental Europe.
- Devakumar uses a personal account from working in an emergency medical relief operation to highlight the role of primary care doctors as advocates for the most vulnerable citizens

The *London Journal of Primary Care* consider these three examples to be nothing more than a re-assertion of traditional general practice values of whole person, community-oriented care to modern-day structures. GPs should be loud in arguing these values within the new emerging NHS.

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