Commentary – Alma Ata

Primary Health Care: an obituary?

John Macdonald

Foundation Chair in Primary Health Care, University of Western Sydney, Australia

The birth year of Primary Health Care is often celebrated as being 1978 and the birthplace as being Alma Ata in what was then the Soviet Union. Despite its humble origins, some hailed the Alma Ata agreement to be of enormous significance in pointing the way to better healthcare systems. The three wise men essential to the tableau of the birth and which mark its significance as heralding a new dawn are Participation, Equity and Inter-Sectoral Collaboration (presumably because these three elements were largely absent in most health regimes). They have been called the three ‘Pillars’ of genuine or ‘strong’ Primary Health Care.¹ Health Care was not (and is not) an area of life that usually encourages the active participation of individuals and communities. Participation requires some genuine form of decision-making by individuals and communities and not token involvement. Equity? – this means some recognition of disadvantage and real attempts to address this. Scandinavia stands out unusually, as a place where equity is a guiding force in the management of health services. There are of course examples where people collaborate across the sectors to build health in communities – education, water and sanitation, and housing – but by and large this inter-sectoral collaboration does not involve those involved in medical practice.

The vision of Primary Health Care

The Declaration of the Conference of Alma Ata is a visionary document that held out a picture of health systems which incorporated affordable, accessible, culturally appropriate healthcare, integrated with other factors which clearly contribute to the health of populations: the economy, schooling, sanitation etc. This is Comprehensive Primary Health Care. There can be no doubt that this was indeed the intention of the conference, agreed to by most nations in the world. Comprehensive Primary Health Care requires integration of health services from tertiary level to grass-root neighbourhood level. This vision had (and even now still has) enormous conceptual appeal. The health system proposed is one in which the symptoms of ill health

are dealt with as they present and referrals made to appropriate levels of care, while at the same time tackles the root causes of problems. It is the old adage of ‘dealing both down-stream and up-stream’ with the health of communities: helping those who have fallen into ill-health ‘down stream’ but being involved in systematic attempts to stop people falling into the river of ill health in the first place.

A simple example of this Primary Health Care approach can be seen with the problem of diarrhoeal disease, potentially a killer in many poorer countries. The Primary Health Care approach is, of course, to treat the symptoms. Or, even better, to help families treat the symptoms (the downstream dimension). But essential to Comprehensive Primary Health Care is involvement upstream – addressing the factors that cause the problem in the first place. It does not require great intellect to recognise that access to clean water and the safe disposal of human waste are essential to health; of course the people (often children) who suffer as a consequence must also be treated. At time this will require referral ‘upwards’ to more specialist care.

A ‘western’ example might be respiratory infections: the people of Easterhouse, Glasgow, combined addressing the symptoms of wheeze in children (downstream) with improvement in damp housing conditions (upstream). This is the message of Comprehensive Primary Health Care. It must be noted that this 1990s example was achieved by a population pushing the medical and political system, not by enlightened GPs. The ‘western’ example is important because Alma Ata was signed off on not just as having relevance to ‘developing’ countries, but as having universal applicability. Alma Ata recognised the great importance of medicine, but assigned to it a ‘place’ in the scheme of things – within systems of health and healthcare, rather always the main player. Alma Ata presumed humility on the part of medical practitioners. Another example comes from men’s health (an area of interest in some countries.² A local government authority in Sydney, Australia, publishes a ‘Blokes Book’: a compendium of contacts useful for male-specific needs, including male counselling, advice for single fathers etc. The doctor does not need to ‘know’ everything for her/his patient but needs to be able to point to resources such as this.

Why an obituary? Is Comprehensive Primary Health Care dead?

To go back to the celebrated birth analogy: just as Herod's soldiers moved in quickly with the order to kill once the news of the special birth was out and its significance realised, one short year after the birth of Primary Health Care, the swords were out. 'Research' was published in 1979, funded by powerful Western sources, acknowledging the value of comprehensiveness and 'participation, equity and inter-sectoral collaboration', but dismissing them as admirable but unrealistic. A trimmed down, manageable and unthreatening saviour was proclaimed: 'Selective Primary Health Care'. As in the case of 'GOBI' (growth monitoring, oral rehydration, breastfeeding and immunisation), the radical dimension of Primary Health Care was replaced by simple technical interventions and exhortations of behavioural change, all manageable by the health profession and safely removing Primary Health Care from the domain of the political. Comprehensive Primary Health Care could be – and often was – replaced by this version.

For others, comprehensive Primary Health Care was considered as being relevant only 'over there' in the countries of the Third World. This is still often the case in Australia where there is not a debate about 'comprehensive Primary Health Care' but about what GPs do or, what Aboriginal communities espouse.

This selective version is still alive and well and has been promoted vigorously by agencies such as UNICEF and the funders of the research behind it – USAID. It is often espoused by philanthropists and those who need to quantify their charity: 'ten dollars will buy oral rehydration salts for 200 families' etc. The causes, the upstream factors, whether of diarrhoeal disease in Nicaragua, or respiratory infections in the post industrial towns of Europe, such as Glasgow can safely be ignored. Acknowledged of course when necessary, but not 'our business'. Medicine does what it can and the three wise men of participation, equity and inter-sectoral collaboration can wait at the door till ... when? It would be true to say that Comprehensive Primary Health Care never really got a look in, in western health systems. Ask any GP what Alma Ata is/was and see the blank look on their face.

The 'unrealistic' vision of Comprehensive Primary Health Care was a genuine call for all health systems across the world to examine themselves, to acknowledge the inescapable political dimension of healthcare delivery, a chance to take seriously the notion of 'health

as a right' and challenge upstream inequities in society which are at the root of so many health problems. It was taken seriously by some countries initially, but by 1993 the World Development Report of the World Bank entitled *Investing in Health*, had signalled both its taking over of the world health agenda and its support of a selective 'vision'.

Comprehensive Primary Health Care is dead in most developing countries and was never really addressed in developed countries. When Primary Health Care is mentioned in the West, it is generally taken to mean accessible general practice with some health promotion added on. No bad thing. But this is not Primary Health Care – it is good primary medical care. As the only Professor of Primary Health Care in Australia I feel sure it is time to either treat seriously the term 'Primary Health Care' or abandon it, to avoid the situation where general practitioners think that they are doing it merely by encouraging life style change on their patients.

Is all doom and gloom then? No: the issue of equity and the wider vision of health and health care underlying the system proposed by Alma Ata are still being promoted by many countries. The rise of interest in social determinants of health is raising some of the important principles of Comprehensive Primary Health Care. Evidence is revealing the enormous importance of social, economic and political factors in health and healthcare. WHO (Europe) highlights these social determinants: social gradient, stress, employment, social support, inclusion/exclusion etc. The evidence of the impact of such factors is overwhelming and makes it difficult to ignore them.

Whatever language we use to describe it, and however hard it may seem to achieve it, we must not lose sight of an old vision – one which sees health systems as both acknowledging the importance of the social determinants and insists that policy and action are directed upstream as well as downstream.

REFERENCES

- 1 Wisner B. *Power and Need in Africa*. London: Earthscan, 1988.
- 2 Department of Health and Ageing. *Developing a Men's Health Policy for Australia*. Department of Health and Ageing, 2008. Available at: www.health.gov.au/menshealthpolicy

ADDRESS FOR CORRESPONDENCE

Email: j.macdonald@uws.edu.au