Opinion

Forty Years After Alma-Ata: At the Intersection of Primary Care and Population Health

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THE DECLARATION OF ALMA-ATA¹ WAS ADOPTED IN SEPTEMBER 1978 at the International Conference on Primary Health Care in Alma Ata (today called Almaty), Kazakhstan. The document was the first international declaration that put primary health care front and center to the goal of achieving health for all, initially with a low-income lens in mind and, soon after, adopted also for high-income countries. The centrality of primary health care has since been adopted as a core organizing goal by the World Health Organization (WHO) and has withstood the test of time despite some early criticism about the breadth and lack of specificity of the original Declaration.²

Forty years later, after a year-long consultation process, the Declaration of Astana³ was ratified at the Global Conference on Primary Health Care in October 2018. The new declaration served to mark and commemorate the 1978 declaration and to renew political and cross-sectoral commitment to its goals. In particular the new declaration is grounded in an appreciation of the central role of primary care in achieving universal health coverage (UHC) and in the sustainable development goals (SDGs) as aspirational goals for the global community looking ahead to 2030. At its core, the Declaration of Astana urges a redoubling of effort toward developing primary health care as a pillar of effective health systems, labeling it “the most inclusive, effective, and efficient approach to enhance people’s physical and mental health as well as social well-being.”³ The declaration envisions a world where we live in health-conducive environments, implying that these are to be achieved through the “bold political choices for health across all sectors” that lead towards sustainable primary health care.

There is much to admire in both the original and the new declarations. The focus on primary care as the mainstay of a sustainable health system

seems indisputable. The new declaration embeds primary care at the heart of UHC, and in the achievement of the SDGs. All of this seems reasonable and right-minded and the global community will be well served by a more robust adherence to the aspirations and commitments articulated in the declaration.

Particularly interesting, from our perspective, are the implications of the Declaration of Astana for the health of populations. While the declaration is anchored in an aspiration for “Health for All,” and suggests that healthy communities have a role in bringing about this goal, the link between primary health care and population health is not made explicit, with the implication being that achieving UHC and better health systems will, perhaps indirectly, get us to healthier populations.

There are two ways that primary care can improve the health of populations. First, primary care can provide crucial preventive and curative services that directly save lives. Recent analyses suggest that high-quality health systems could avert 8.6 million deaths annually in low- and middle-income countries alone from infectious and chronic diseases; many of the most powerful interventions are situated at the primary care level.⁴ However, this promise is predicated on good quality care, which is far from the reality in many countries, particularly the poorest. Even as access improves, quality of care for basic conditions falls short of good clinical practice and people’s expectations.⁵

Second, primary care can play a much larger role in promoting the conditions that make people healthy. Health systems, regardless how effective, are only partly responsible for the production of health, helping to prevent disease and restore people to health if they are sick. The health of populations, however, is produced by the social, economic, and political conditions within which we live, the air we breathe, the water we drink, the food we eat, the safety of our environments, the support of our social networks, and the opportunities opened up to us by our educational experiences.

How then do we reconcile a global push for deeper engagement with primary care and UHC together with an appreciation of the ineluctable role of the more foundational drivers of population health?

We would suggest that primary care can serve to bridge the gap between clinical medicine and population health. Primary care providers work at the frontier of the health system, close to people. They deal with the full range of human conditions, aiming both to avoid disease and to treat a broad range of illnesses that are amenable to intervention without

needing recourse to specialist care. Moreover, primary care providers are well positioned to see and act on the structural conditions that produce disease. A child in a low-income country contracts malaria not only because she has been bitten by a mosquito, but also because she has not had access to treated mosquito nets, owing to her parents' poverty, or isolation, or life in a war-torn country. A middle-aged woman in a high-income country who is 40 pounds overweight and suffering from osteoarthritis in her knees, soon to require knee replacement surgery, has been overweight all her life because of the widespread availability of calorie-dense, nutrient-poor food, coupled with limited social opportunity and exposure to healthier lifestyles. Therefore, while it is the primary care practitioner's role to treat the malaria and mitigate the osteoarthritis, it is also the primary care practitioner who is most acutely aware of the social and economic conditions that make a person a patient, that chip away at our opportunity to live healthy lives, and that push us to require engagement with the health systems to restore us to health in the first place.

The aspiration of primary care to be the central means for realizing the human right to health is inseparable from the goal of creating a world that generates health and not disease. While at some level this is true of all of medicine, it is also true that regardless of the conditions around us, pathology *will* happen and we are all well served by having technical expertise in the form of advanced clinical care to restore us to health. Primary care, however, by its very scope, deals primarily with conditions that are largely preventable and closely linked through the causal chain to their social or environmental cause. This should make primary care and population health intimate bedfellows.

The Declaration of Astana reinforces this observation by invoking "Health for All" as a core goal and suggesting that the primary health care agenda, at the heart of UHC, should emerge from political will towards achieving better health. We applaud the conflation of these two ideas but argue for an even greater synthesis, suggesting that the two are not separate ideas at all. Primary health care should exist to protect and promote the health of populations. It simply cannot achieve that without engaging with foundational social and economic forces, and without tangling with the causes of the health of populations. When viewed this way, primary care's clinical function—the restitution of health for those who are sick—complements its political function, embracing the challenges needed to create a world where populations are not sick to

begin with. A recognition of the inexorably political role of primary care may be a step too far for the global community in 2018, which still views health as primarily a technical endeavor. But the Declaration of Astana advances on the Declaration of Alma-Ata by putting the UHC imperative—with primary health care at its core—front and center. As our appreciation of the determinants of population health matures, we can aim to go further, toward a primary health care that sees its work as inseparable from the determinants of population health. That would seem to us a worthy aspiration for the next forty years.

References

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