The Alma-Ata legacy, 40 years later

Some years ago, I had the opportunity of talking to Halfdan Mahler, Director-General of the World Health Organization (WHO) in 1978, the year in which the International Conference on Primary Health Care (PHC), was held in Almaty (formerly Alma-Ata), Kazakhstan (formerly Kazakh Soviet Socialist Republic), which resulted in the Declaration of Primary Health Care. I asked Mahler if he thought that any country in the world had really implemented PHC. He answered that the countries that were the closest to reaching this ideal were those of Northern Europe, where there were good social and sanitary infrastructure and strong equity principles, as well as the universal right to health.

I believe that this answer is related to the generalized perception that the comprehensive postulates of the Declaration of Alma-Ata were never implemented, and what prevailed was the so-called Selective Primary Health Care (Cueto, 2004). This version of the PHC emphasized technocratic interventions that were "cost-effective", executed by health professionals, in a care structure that postponed prevention. According to this perspective, disease would be a natural and biological phenomenon – not a social one –, and the main factor to fight against diseases would be the health services.

During the 1980s and 1990s, a period marked by neoliberalism, PHC was the main model of the health agencies and of the new players in international health, the World Bank among them. This technocratic perspective complemented other neoliberal reforms, like the privatization of public services, the deregulation of markets, the proliferation of public–private partnerships, and a decrease in the role of the State. The neoliberal reforms implied a managerial handling of the state services, presupposing that the private sector would be more efficient than the public sector. However, at the turn of the 21st century, in spite of the neoliberal promises that created the expectation that its structural adjustment programs would reduce poverty, neoliberal economic growth produced extensive social inequalities, the proliferation of unemployment, partial and poorly-paid jobs, as well as the expansion of poverty in many countries.

The contradictory legacy of PHC in this context of crisis in neoliberalism strengthened two perspectives in global health whose history began in the 19th century, when social medicine and the biomedical answers to health problems emerged (Cueto, 2015). Firstly, a perspective linked to social medicine that promotes comprehensive interventions, values the participation of the community, and considers sanitary doctors agents of social change and health as a human right. Secondly, a technocratic perspective, which is put into effect by an elite of

specialists that consider the improvement in health as a way of controlling disease outbreaks, of providing an assistential hospital care, and of contributing to the economic development of a liberal society.

Over the past 13 years, after a WHO Assembly that was celebrated in 2005, these two perspectives became known as: Social Determinants of Health (SDHs) and Universal Health Coverage (UHC). The SDH perspective is linked to the Commission on Social Determinants of Health as an independent unit of the WHO composed of sanitary doctors who are well-known for their progressive ideas, like Michael Marmot, from England, and Pascoal Mocumbi, from Mozambique.

According to this Commission, the social determinants are *the cause of the causes*. The SDHs are considered indicators of the social and economic conditions in which people live, such as salary, education, employment, housing, diet and sanitation. The concept of the SDHs brought about a different perspective of the concept of health that was already included in the Declaration of Alma-Ata: the well-being of a population is the result not only of the medical services, but mostly of the influence of the social conditions in which people are born, grow up, work, and grow old. Such vision was similar to the postulates of the many reports on equity in health of the 1970s, which inspired the 1978 Declaration of Alma-Ata. The SDH advocates consider that the inequities in health are avoidable, unfair and unnecessary, and can be changed through assertive political actions. Another similarity between the SDHs and the Declaration of Alma-Ata is the implication of a model of society in which equity and solidarity would be the mortar of its construction. Thus, PHC and the SDHs were proposed as if public health constituted a tool to change society.

In 2008, the Commission on Social Determinants of Health published a report called "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health", which presented a commitment to reduce over the course of a few years the inequalities in health. Even though the Member States of the WHO signed the report in the 2009 World Health Assembly, the future of this perspective is still uncertain. However, a phenomenon that is similar to what happened with the original PHC proposal that I mentioned at the beginning of the text has been going on: the SDHs are being turned into one of the causes championed social movements, and – with the exception of a few countries – there still is not even so much as a commitment on the part of the governments to make the SDHs the core of the social policies.

Almost at the same time, an alternative perspective to the SDHs emerged: UHC. Universal Health Coverage contemplates interconnected goals: to increase the access to health services; to decrease the financial hardships of the people

who use and pay for these services with their own money; and to maintain the financial stability of the welfare systems.

In its most ambitious version, UHC would create the conditions for the only egalitarian dimension in a liberal society: equality of opportunity. This dimension meant that the State should guarantee to its citizens the same possibilities of access to individual development through a decrease in the discrimination due to race, sex, ethnicity, age religion or sexual identity. The idea of equality of opportunity did not contrast with the general social inequalities and the great disparities in income distribution. On the contrary, it was – ideally – the basis of a genuine meritocracy, with social inequalities. This liberal ideal of meritocracy, aside from being unachievable, in fact aims to mask social injustices.

However, an economic factor radically changed the context of these two global health proposals: the bank crisis that began in 2008. In that year, the most important financial institutions in the world reported losses in their budgets in the order of billions of dollars. In order to avoid collapse and the atmosphere of generalized distrust, the governments of the United States and of many European countries decided to set aside their neoliberal theories and aid these institutions through trillion-dollar bailout packages, in order to avoid the bankruptcy of the banks.

The austerity measures in high-income countries put in doubt the possibility of the international health agencies of making ambitious proposals. The SDHs were a topic that was postponed in many agencies and governments. Universal Health Coverage was transformed into a set of limited number of treatments that could be provided to the disadvantaged population. At the same time, the progressive disempowerment of the WHO became evident because this agency did not have control of 80% of its budget formed by directed donations, because it did not have true supranational authority, and because it depended on powerful donors who were interested in technocratic health programs, like the Bill & Melinda Gates Foundation. Thus, problems regarding governance, leadership and the priorities in global health were created, and they can be summarized as the result of the absence of interaction among the main institutions, and of the absence of transparency regarding the link between the PHC proposals and the society models.

Over the past few years, there has been a debate over the lack of comprehension of the Alma-Ata postulates. Many authors point out the problems with the understanding of PHC as the mere expansion of the coverage of the health services in rural areas and low-income communities, the absence of financial resources and of a true political commitment, and the resistance on the part of the medical schools that promoted the training of professionals who worked with sophisticated and costly technologies in

cities. All of these explanations are right. However, I believe that there are two additional problems. Firstly, the insufficient effort made by the PHC advocates of eliminating a survival culture that historically has been an essential part of public health. Secondly, the scarce effort of highlighting the link between the Alma-Ata postulates and the model of society that the sanitary doctors must seek: a society in which the priorities are education and health, and not military spending; and in which equity and solidarity are the main goals of all social players.

We now live in the midst of a confusion of the differences between the two health proposals, with little understanding of its particularities. As a result, there are no clear and strategic sanitary proposals about what to do since health with the social inequalities and the role of the sanitary doctors in the political and economic crisis.

Unfortunately, in this established confusion, the enemies of the egalitarian proposal of public health have a wider political turf, and seem ready to make real a society in which there is a public health that does not even have the UHC principles; in fact, a precarious and semiprivatized public health that coexists with a State without means of promoting the improvement of living conditions or the modernization of the human resources of a health system with passing and fleeting responses.

Fortunately, the history of PHC and of international health show that the two proposals go through cycles, and that the periods in which health has and does not have long-term strategies also go through cycles. The social focus that appeared in the Mahler version in the Declaration of Alma-Ata, in the distant year of 1978, resurfaced in the documents of the Commission on Social Determinants of Health, and it may once again become hegemonic with the help of the health activists and progressive sanitary doctors. Selective PHC, which glorified a package of treatments and had great similarities with the UHC, may lose the popularity it enjoys today within the global agencies. It is up to us to decide which perspective shall be hegemonic in the future. The PHC inspired by the Declaration of Alma-Ata is a strategy that must not be forgotten.

Marcos Cueto
Editor of the journal *História, Ciências, Saúde - Manguinhos*, Oswaldo Cruz Foundation, Oswaldo Cruz House, Rio de Janeiro, RJ, Brazil.
<marcos.cueto@fiocruz.br>

References

CUETO, Marcos. The Origins of Primary Health Care and Selective Primary Health Care. *American Journal of Public Health*, v. 94, n. 11, p. 1.864-1.887, 2004.

CUETO, Marcos. *Saúde global:* uma breve história. Rio de Janeiro: Editora Fiocruz, 2015.