1.1. Thirty years after Alma Ata: the development of global health policy

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The right to health, the goal of health for all, and Primary Health Care

The Constitution of the World Health Organization (WHO) recognises that health "is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"[1]. Since being cited in the Universal Declaration of Human Rights[2], the right to health has been raised at a number of international summits and has been translated into binding instruments for ratifying countries. By the end of the 1970s, it seemed as though the concept of health as a human right had been well and truly established. In 1977 the 30th World Health Assembly ratified the goal of "Health for All by the Year 2000". As a continuation of this policy, the Alma Ata conference the following year identified Primary Health Care (PHC) as a strategy to achieve this difficult objective[3]. The Declaration of Alma Ata aimed to achieve health for all by the year 2000 by providing essential health care as an integral part of a country's health care system; its main aim, however, was "the overall social and economic development" of the community, in a vision based on equity, community participation, a prevention-driven approach, appropriate technology and a cross-sector and holistic approach to development[4].

The implementation of PHC needed health systems to redirect their policies, strategies and resource allocation, requirements that ran into a host of cultural and political barriers. The need to focus on rural areas and the most deprived urban ones, basic health care, as well as the primary needs and pathologies of the poorest people, met with resistance from the social hierarchy and power base in many developing countries. The economic, political and intellectual elite pushed for hospital health care services that were highly specialised, costly and unsustainable. Doctors' income, as well as their social and professional standing, was, and still is, linked to their level of specialisation and to technological sophistication rather than to adding value to the service provided by general practitioners in the most run-down areas. Ministries of Health have often had very little political weight for a whole host of reasons, not least because their budgets are determined by the decisions of financial ministries. Consequently, the implications were not lost on a medical profession that was more concerned about dealing with the clinical aspects of disease rather than the social ones. Furthermore, countries that were more determined to introduce PHC had to face obstacles thrown up by a lack of both financial and human resources, a plight that affects all developing countries to different extents.

As a response to the complexity of implementing PHC, a new current of thought developed. Nowadays the more dominant of the two, Selective Primary Health Care narrowed down the original innovative current of thought and concentrated on the application of selective measures that "should be aimed at preventing and managing those few diseases that cause the greatest mortality and morbidity and for which there are medical interventions of relatively high efficacy"[5]. These measures were selected according to questionable cost-effectiveness criteria. Programmes to deal with individual diseases or conditions that had been identified with the above criteria were drawn up at central level and then implemented throughout the country (or throughout the world) in the same way, and often with rigidly assigned resources. Separate institutions were even set up for each programme; at that time, it was common for special independent bodies to be set up to eradicate malaria. These programmes were organized according to top-down dynamics, often called a vertical approach, in contrast with the bottom-up model of PHC, which would have seen local communities make the decisions. The introduction of relatively economical, high profile, bespoke campaigns also aimed to conceal the lack of political determination that was needed to overhaul the health system. A disease-driven rather than a health-driven approach corresponded to Western models and in some cases was more suited to the political or administrative requirements of donor countries and international organizations; the use of their own specific items of expenditure for Official Development Assistance (ODA) was one. This approach was also easier to market and disseminate through the media (e.g. by social marketing).

The reorganization of health care systems into vertical programmes (e.g. vaccinations, family planning, control of individual diseases, etc.) led to the break up of public health action in many countries, with an increase in costs and a waste of resources, not to mention completely isolating it from development in other sectors, such as education, agriculture and production. Likewise, WHO gave far more importance to disease programmes and divisions than to resources for the development of health care systems and to integrated action for health promotion. Attention had strayed away from health and was concentrating on diseases.

International financial organizations and health care system reform

As the selective approach did not require huge investments in public health and system reorganization, it suited the Reaganite-Thatcherite neo-liberal macroeconomic policies that had started to take hold in the early 1980s. A looming debt crisis and a radical attack on aid policies led to the rise of macroeconomic recipes and Structural Adjustment Programs (SAPs), which international financial organizations such as the International Monetary Fund and the World Bank imposed on individual countries as a condition for ODA. SAPs aimed to enable developing countries to pay back the debts they had taken out with commercial banks and required the "reduction/removal of direct State intervention in the economy's production and redistribution sectors"[6]. The conditions SAPs envisaged included slashing

public expenditure; liberalising imports and removing restrictions on foreign investment; privatising state companies and financial deregulation; devaluing currency; cutting wages and weakening labour protection mechanisms. By way of a technical appendix to adjustment policy, in 1987 the World Bank published *Financing Health Care: an Agenda for Reform*. Privatisation, payment for public health care services, and government decentralisation of health care became the new cornerstones of international debate[7]. Adjustment policies had a dramatic effect on large swathes of the population and forced social safety nets and welfare support provisions to be introduced alongside SAPs in order to reduce their effects.

In the meantime, the Declaration of Alma Ata continued to inspire other proposals. At the Harare Conference in 1987, decentralisation was again raised as a means of applying PHC, with districts being promoted as the best way of identifying the underserved and aligning health intervention[8]. Likewise, the concept of Local Health Systems (SILOS)*, later proposed by the Pan American Health Organization (PAHO), made a return to equity and quality of services, democratization and social participation, with health, wellbeing and development being viewed as integral concepts[9]. In accordance with the target of Health for All by the Year 2000, emphasis was once again placed on cross-sector health promotion by the Ottawa Charter, which was drawn up at the end of the First International Conference on Health Promotion in 1986, introducing the idea of public health policies and thus health as the objective of all public intervention[10].

The World Bank's proposals, however, were not heading in the same direction. In 1993, it published its annual report, entitled *Investing in health*, which confirmed its position as the new force in international health. The report proposed updating the selective approach by promoting the introduction of a minimum essential package on which public health action for the poor could focus. It promoted health system reform based on progressive privatisation with the transfer of health system costs onto the user with user fees, community financing and health insurance[11].

The reform was at the centre of international debate throughout the 1990s, while "increasing interdependence and globalization [were] clearly challenging national control of health policy"[12]. The global health system model introduced by the reform soon produced devastating consequences in terms of soaring private health care costs and impoverishment of families, triggering what is known as the 'medical poverty trap'[13]. By the mid-1990s, the World Bank had become by far the biggest international financer of health activities in countries with low-medium income. The sheer volume of its financing and the associated conditions enabled the World Bank to progressively alter sector priorities and the relationship between donors and beneficiaries, both globally and nationally[14].

* From the Spanish acronym for *Sistemas Locales de Salud.*

Health: from fighting poverty to global vertical initiatives

During the 1990s, widespread debate at a string of international summits** aimed to redefine the world agenda for economic and social development, with the result that attention began to be focused on fighting poverty. Debate centred upon *Shaping the 21st century: the contribution of development co-operation*, a report by the Organization for Economic Cooperation and Development (OECD)[15] that laid the foundations for what would lead to the Millennium Declaration in 2000. This report was followed by the OECD's approval of the Development Assistance Committee's (DAC) Guidelines on Poverty Reduction[16], which highlighted the importance of health intervention and the need for an aligned approach that would unite local public and private players with the donor community in the development of national strategies.

In 1999 the World Bank and the International Monetary Fund started to hint at reducing poverty by including access to subsidised credit and debt relief in their *Poverty Reduction Strategy Papers* (PRSP), national plans that envisaged the involvement of a range of local public and private players[17]. A decade of decadence followed the retirement of Halfdan Mahler, the charismatic head of WHO between 1973 and 1988 and a pioneer of the Declaration of Alma Ata. However the election of Gro Harlem Brundtland as Director General in 1998 was met with a wave of fresh enthusiasm for the social component of development, and it was believed that WHO finally had the opportunity to win back faith and influence as the leading promoter of public health. On its appointment, the new executive added the fight against poverty, underdevelopment and social inequality to WHO's objectives. In 2000, WHO focused its annual report on health systems by measuring performance in terms of health production and adding value to aspects such as equity, risk-sharing and meeting the expectations of health system users, as well as stressing a cross-sector approach to health promotion[18]. Under Brundtland's leadership, WHO sponsored a host of international vertical initiatives such as *Stop Tuberculosis*, *Roll Back Malaria*, *Malaria Medicines Initiative*, *International Partnership against AIDS in Africa*, *International AIDS vaccine initiative*, and *Global Alliance for Vaccines and Immunisation*. Although these initiatives were inconsistent with the systems approach, they were in line with the emergence of new forms of global collaboration between the public and private sectors (i.e. not-for-profit and for-profit) known as Global Public Private Partnerships (GPPP).

In 2001, WHO report *Macroeconomics and health: investing in health for economic development* reinforced the theory that investments in basic health care would lead to economic advantages, stating that the foreign aid required by developing countries would be at least 22 billion dollars per year, in addition to the 6 or so billion dollars that had already been invested. The report, however, failed to analyse the macroeconomic and political causes underlying the dramatic situation

** In particular the UN summit for Children in New York in 1990; the Rio de Janeiro conference on Environment in 1992; the Cairo conference on Population in 1994; the Beijing conference on Women in 1995; the Istanbul conference on Habitat in 1996; and the Copenhagen conference on Social Development in 1995.

of global health; nor did it raise solutions beyond appealing for more resources. Instead it hid behind initiatives that had already been promoted elsewhere, such as the GPPPs. These initiatives included the *Global Fund to fight HIV/AIDS, Tuberculosis and Malaria*, launched by the G8, and a *Global Health Research Fund* to finance essential biomedical research, which was not followed through[19]. Two years later, however, WHO was in two minds as it started to doubt whether these initiatives could be sustained and governed. It went back to insisting on an aligned and cross-sector approach to health intervention in the wider context of the fight against poverty[20].

The HIV/AIDS epidemic thrust health back onto the international agenda. At the start of 2000, the United Nations Security Council dealt with a health issue for the very first time in its history. In June Secretary General Kofi Annan presented *A better world for all*, a report that, amongst other things, stated that major obstacles to success were "inequities in income, education and access to health care, as well as unequal opportunities between men and women", two reasons for this being a decline in development assistance and inconsistencies in donor policies[21]. The Millennium Summit, which took place in New York in 2000, was expected to provide new answers and direction. Health is the subject of three of the eight Millennium Development Goals (MDG) approved with the summit's closing declaration. These goals, however, were not new; their main aim was to extend the deadline for the goals set in 1990 to 2015 as most of them had been missed. The debate on how to achieve these goals was still very much open. The risk was that attention and resources would be devoted to individual goals as there was no systems-based vision, thus losing sight of the goal of reducing the poverty that these objectives measured. Likewise, the introduction of individual single-theme GPPPs, as opposed to a global alliance for development based on sharing responsibilities among players, lessened the importance of the overall vision contained in the eighth MDG[22].

Although action between the public and private sectors started as a partnership based on social responsibility for development that went beyond traditional bilateral or multilateral players, by the end of the 1990s these partnerships had become joint ventures organized around specific issues. This new model came of age with the establishment of the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria set up by the G8 in Genoa 2001[23]. In a u-turn on the Paris Declaration[24], which promoted a policy of alignment and harmonization to maximise ODA effectiveness, a new organization was proposed for each problem and disease, a new manager that would see governments and the private sector work together. Introduced for clearly ideological reasons, GPPPs weakened the already fragile heath systems of poor countries even further. In a bid to reverse this trend, the concept of health as a fundamental human right was reintroduced. Impetus was given to this issue with debate promoted by the Commission on Social Determinants of Health, which was launched by WHO in March 2005 and presented its report in September 2008. The aim of this commission was to demonstrate that health would be improved by intervention and policies that enhanced the social conditions in which people live and work[25]. The 6th World Conference on Health Promotion[26] held in Bangkok in 2005 reaffirmed the principles that had been expressed in Ottawa, but

made its recommendations in what was by then a strongly globalized context; it urged "effective mechanisms for global governance for health" in order to address "the harmful effects of trade, products, services, and marketing strategies". Alongside government responsibility, it recognised the role that communities and civil society can play through responsible consumption and called for the private sector to behave ethically and implement responsible business practices.

When China's Margaret Chan took over as Director General of WHO in 2007 after the unexpected death of Korea's Jong-wook Lee, she once again stressed the importance of PHC as a strategy to strengthen health systems, but set it in a globalized context that faced new challenges including urbanization, an ageing population, environmental pollution, changing lifestyle and its consequences on health, increased prevalence of chronic illnesses, obesity, the emergence of new infectious diseases and the reappearance of antibiotic-resistant old ones, migration, labour market globalization and the removal of health workers from countries where they were most needed, an increased divide between North and South, urban and rural areas, and rich and poor. "Powerful partnerships have formed. The number of implementing agencies working in health is far greater than that in any other sector. The number of funding mechanisms continues to grow, as does the size of resources they command. Health has never before received such attention or enjoyed such wealth". However Chan also notes "the power of interventions is not matched by the power of health systems to deliver them to those in greatest need". She continues, "In fact, of all the [Millennium Development] goals, those pertaining directly to health are the least likely to be met". Furthermore, she states that the Millennium Development Goals can only be achieved by a return to the values, principles and approach of PHC. She believes that PHC is the best route towards universal coverage, the best way to ensure that health improvements are sustained, and the best guarantee for equity in access[27].

It seems that WHO wants to make a fresh start basing itself on Alma Ata in a globalized world with two clashing visions of the future. The first vision does not dispute the market's rules as "individuals, households, and national economies have to 'earn their keep' in the global marketplace. [...] This vision does not preclude social policy interventions, but they must be justified in terms of the return on investment"[28]. The second states that it is indispensable to limit the negative impact of the emerging global market, and social justice is to be promoted; access to health care services is a prerequisite if health is to be recognised as a human right, and the necessary resources are available; it is possible to have globalization that recognises the existence of social obligations and global governance that ensures they are met; there must be "a regulatory framework for global market forces that is people-centred rather than capital-driven"[29]. Thirty years after Alma Ata, the prevalence of one vision over another will depend mainly on the role of its players and on how the balance between global governance and health strategies develop.

References

[1] WHO, *Constitution of the World Health Organisation*, in *Basic Documents*, 42nd Edition, Geneva 1999, p. 1.

[2] United Nations, *Universal Declaration of Human Rights*, approved by the UN General Assembly on 10 December 1948.

[3] G. Maciocco, *La salute come merce: da Alma Ata all'epidemia globale delle riforme sanitarie*, in Osservatorio Italiano sulla Salute Globale. *Rapporto 2004 Salute e globalizzazione*, Feltrinelli, Milano 2004, pp. 87-108.

[4] WHO/UNICEF, *Alma-Ata, Primary Health Care,* Health for All series n. 1, Geneva 1978.

[5] J.A. Walsh, K.S. Warren, *Selective primary health care: an interim strategy for disease control in developing countries*, «New England Journal of Medicine» 1979, 301, pp. 967-974.

[6] W. Bello, *Il futuro incerto. Globalizzazione e nuova resistenza*, Baldini & Castoldi, Milano 2002, pp. 40-43.

[7] A. Stefanini, *Salute e mercato. Una prospettiva dal Sud al Nord del pianeta*, EMI, Bologna 1997, pp. 57-59.

[8] WHO, *Interregional Meeting on Strengthening district health systems*, Harare, 3-7 August 1987.

[9] J.M. Paganini, A.H. Chorny, *Los sistemas locales de salud: desafíos para la década de los noventa*, «Boletín de la Oficina Sanitaria Panamericana» 1990, 109, pp. 424-448.

[10] WHO, *Ottawa Charter for Health Promotion*, 1st International Conference on Health Promotion, Ottawa, 21 November 1986 - WHO/HPR/HEP/95.1.

[11] World Bank, *World Development Report 1993: investing in health*, Oxford University Press, Oxford 1993.

[12] G. Walt, *Globalization of international health*, «Lancet» 1998, 351, pp. 434-437.

[13] G. Maciocco, See above.

[14] K. Buse, C. Gwin, *The World Bank and global cooperation in health: the case of Bangladesh*, «Lancet» 1998, 351, pp. 665-669.

[15] OECD/DAC, *Shaping the 21st Century: the contribution of Development Co-operation*, OECD, Paris 1996.

[16] OECD, *The DAC guidelines. Poverty reduction,* OECD, Paris 2001.

[17] World Bank, *Overview of Poverty Reduction Strategies, 2003* (last access 30/09/2004) http://www.worldbank.org/poverty/strategies/overview.htm

[18] WHO, *The World Health Report 2000,* WHO, Geneva 2000.

[19] WHO, *Macroeconomics and health: investing in health for economic development*, WHO, Geneva 2001 http://www3.who.int/whosis/menu.cfm?path=whosis,cmh&language=english

[20] OECD/DAC, *Poverty and Health. DAC guidelines and reference series,* OECD-WHO, Paris 2003.

[21] UN, Press release PI/1261 SOC/4549, Geneva, 26 June 2000.

[22] E. Missoni, G. Pacileo, *Le politiche delle Organizzazioni Internazionali e gli obiettivi di sviluppo del Millennio*, in *A caro prezzo. Le diseguaglianze nella salute*. 2nd report by Italian Observatory on Global Health, Edizioni ETS, Pisa 2006, pp. 150-163.

[23] E. Missoni, *Il Fondo globale per la lotta all'HIV-Aids, la tubercolosi e la malaria*, in Italian Observatory on Global Health. 2004 report. *Health and Globalization*, Feltrinelli, Milano 2004, pp. 221-232.

[24] OECD/DAC, *Paris Declaration on Aid Effectiveness,* High Level Forum, Paris, February 28 - March 2, 2005.

[25] WHO, www.who.int/social_determinants/about/en (last access 18/01/2008).

[26] WHO, *The Bangkok Charter for Health Promotion in a Globalised World*, 6th Global Conference on Health promotion, Bangkok, Thailand, August 2005.

[27] M. Chan, *Keynote address at the International Seminar on Primary Health Care in Rural China*, Beijing, 1 November 2007.

[28] R. Labonte, T. Schrecker, *Globalization and social determinants of health: promoting health equity in global governance (part 3 of 3)*, «Globalization and Health» 2007, 3, p. 7.

[29] R. Labonte, T. Schrecker, *ibidem.*